MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04967 CERTIFICATE OF DEATH funeral s 1 and 2 ter death. death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a, STATE b. COUNTY a. COUNTY MARYLAND the death certificate be executed within 24 hours after b. CITY OR TOWN (If outside carparate limits, c. LENGTH OF STAY IN 16 TOWN (Ill outside carparate limits, write RURAL and give nearest town) write RURAL and give pearest town) IS RESIDENCE filled in d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS ON A FARM? YES NO C 3. NAME OF DATE F09 Last Month Day Year DECEASED BANKERT CHARLES 1967 (Type or print) DEATH IF UNDER 24 HRS. 9. AGE (In years IF UNDER I YEAR SEX 6. COLOR OR RACE NEVER MARRIED DATE OF BIRTH 7. MARRIED emore pirthday) Months Dovs Hours DIVORCED WIDOWED 12, CITIZEN OF WHAT 10b. KIND OF BUSINESS OR COUNTRY? lease during most of working life, even if retired) owner - manager 13. FATHER'S NAME or remova James IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, grunknawn) (If yes give, wor or dates of service) CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-tronsit is burial, cremati ONSET AND DEATH PART I. DEATH WAS CAUSED BY: requires that IMMEDIATE CAUSE (o) call carcinoma Conditions, if any, which gave rise to immediate couse (a). DUF TO stoting the underlying couse os the prior to has been last. WAS AUTOPS'
PERFORMED? PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO YES by the hospital or **DIRECTOR:** After this certificate jo 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING I CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Manth, Day, Year Hour o.m. factory, street, office bldg., etc.) Nat While of work of work 21. I certify that (1) (this haspital) attended the deceased from Sessel 1966 to afril 7. . 1962, that (I) (we) last be retoined 19.6), and that death accurred at PM, fram causes and an the date stated above. saw the deceased alive an amil'7, 22o. SIGNATURE 22b. DATE SIGNED ATTENDING M.D. PHYS. DIRECTOR PHYS. filed director, poge should be filed 22d. ADDRESS 22c. PHYSICIAN'S O FUNERAL NAME (Type) extru OHIN 23c. NAME OF CEMETERY-OR CREMATOR JOCATION (City or Town) (State) 23o. BURIAL, CREMATION, 23b. DATE THEREO! 23d. (County) REMOVAL (Specify) EUNERAL DIRECTOR REC'D BY REGISTRAR 25b. REDISTRAR'S SIGNATURE

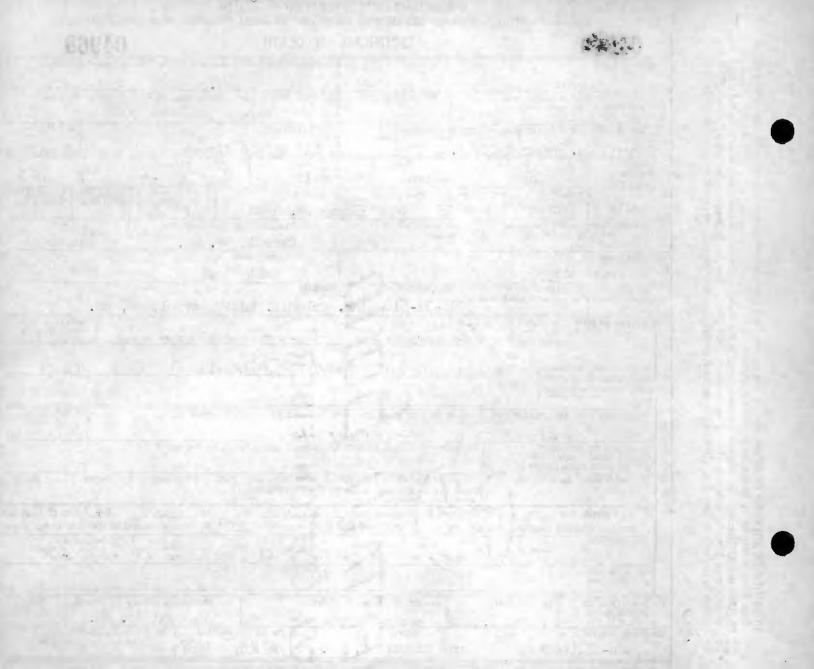
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04968 CERTIFICATE OF DEATH TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please there carban papers. Pages Form should be filed with the State Dept. of Health prior to burial, crematian, or removal, and in any eyent, within 72 hours after death TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the haspital or attending physician.

VR A15 (4) 20 M 1/66

		a. COUNTY						Where deceased lived, it		ence betar	e admissio	on)
			rroll	MARYLA	ND	o. STATE b. COUNTY Md. Carroll				077		
	b. CITY OR TOWN (if autside carparate limits, c. LENGTH OF STAY IN 1b write RURAL and give nearest town)						c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)					
		Westminster					Hampstead 16:1				NENCE	
100		d. NAME OF HOSPITAL DR INSTITUTION (If nat in haspital, give street address)								ON A F	ARM?	
		Carroll Co. General Hospt.					215 \(\frac{1}{2}\) Main Street YES				YES [NO L
	3. NAME OF First DECEASED (Type or print) Tda			Middle Hele m a	Middle Helema		4. DATE OF DEATH	Month	Day	Yes	0 km	
	S.	SEX	6. COLOR OR RACE	7. MARRI	ED NEVER MARRIED	8.	DATE OF BIRTH	9. AGE (In y	ears IF UNDE	R I YEAR	IF UNDER	
	_	Female	White	WIDOW	Table 1		y 22, 1896		Yrs.		Haurs	Min.
	during mast at working life, even if retired) INDUSTRY						& State, ar foreign countri 1 Co. Md.		CITIZEN OI COUNTRY? USA			
	13.	FATHER'S NAME				1	14. MDTHER'S MAIDEN NAME					
		Jonas	Lippy				Emi 7	y Lowe				
			R IN U.S. ARMED FORCES?		16. SOCIAL SECURITY NO.	17. INF	ORMANT		Address			
	(16	NO NO	(If yes give war ar dates a	T Service)	218-32-5104	Mr.	Orion E. H	Belt Carro	llton, M	/d.		
			e cause (a), ((a) Co 10 (b) ZA	EVINATIC		HEART DI	FAILL	RE.		ERVAL BET SET AND D EK	
2	NOI	PART II. OTHER SI			NG TO DEATH BUT NOT RELAT			NDITION GIVEN IN PART	1(a)		WAS AUTO PERFORM	ED?
	PULMENAR EMPH SEAR 20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Haur a.m. p.m. 19 While atwark atwark of factory, street, office bidg., etc.)							11	S	NO 🔛		
									(C	aunty)	((State)
		21. I certify that (1) (this haspital) attended the deceased fram 3/25, 1967, ta 4/1, 1967, that (1) (we) last saw the deceased glive an 4/1 1967, and that death accurred at 4/3 M, fram causes and an the date stated above.										
1		22c PHYSICIAN'S NAME (Type	cent of	fer	oca D	M.D.	ATTENDING PHYS. 22d. ADDRESS	MED. DIRECTOR D STAF	F	DATESIGN	67	
2	j	BURIAL, CREMATIC REMOVAL (Specify BUTLA!	April		23c. NAME OF CEMETE 267 Wesley (ery		y ar Tawn) 11 Co. I			tate)
7			Cline Funer	al Ho	7.000 (1000)	d, Md			Milarl	es fr	idge	1

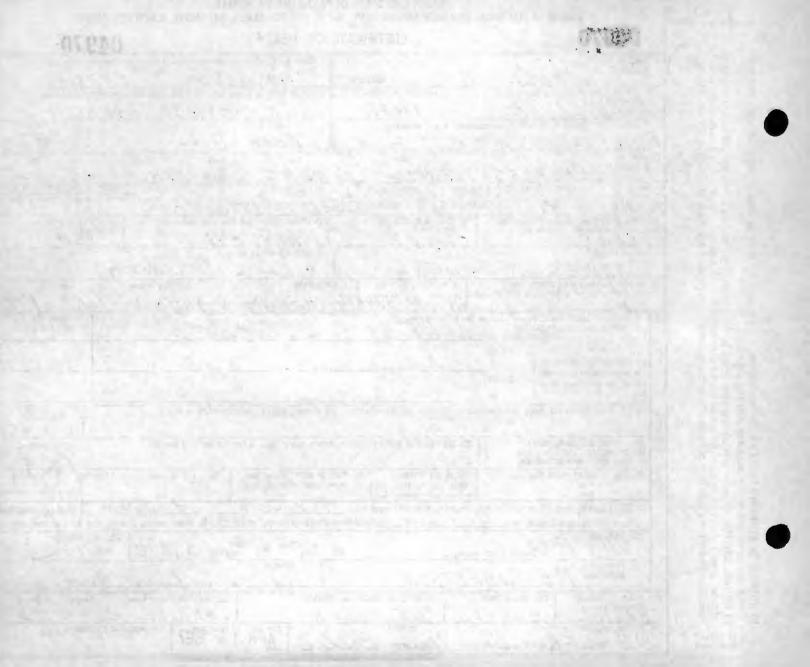
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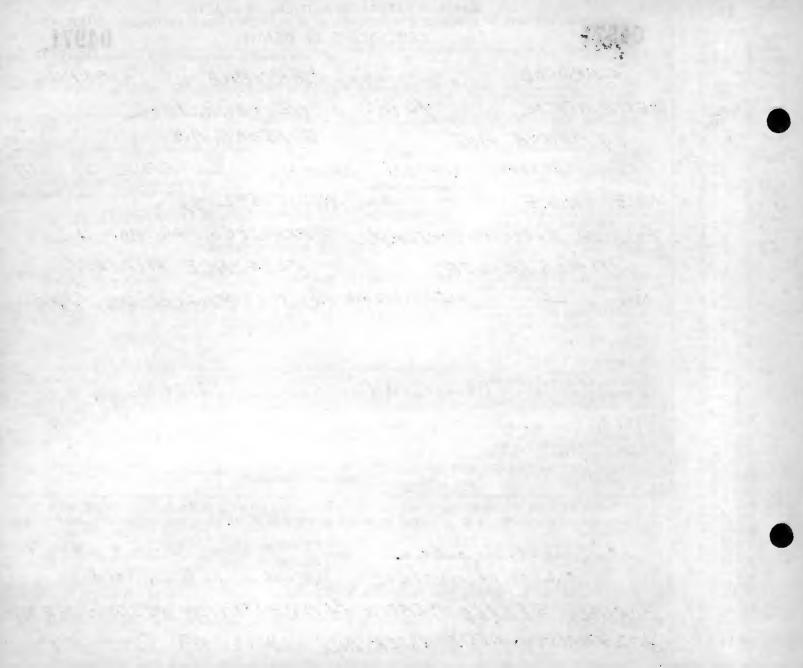
11 = 40-1-74 of the same of the To the state of th

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04970 CERTIFICATE OF DEATH the death certificate be executed within 24 hours after death. death funeral ond PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) D. STATE b. COUNTY after MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) C. LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) in 72 hours URAL papers. d. NAME OF HOSPITAL OR INSTITUTION (if not in haspital, give street address) d STREET ADDRESS e. IS RESIDENCE ON A EARM? YES V NO [corbon NAME OF ** Middle 4. DATE Last Month Year Dov completely DECEASED OF DEATH event, (Type or print) SEX IF UNDER 1 YEAR 7. MARRIED DATE OF BIRTH AGE (In years NEVER MARRIED remove last birthday) Months Dovs Hours In any WIDOWED DIVORCED puo 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of warking life, even if retired) INDUSTRY N/N COUNTRY? physicion puo ARYLAND 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal, offending phys BOWERS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, na, ar unknown) (If yes give war ar dates af service cremotion, 1B. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN buriol-tronsit ONSET AND DEATH IMMEDIATE CAUSE (a) O HOSPITAL OR ATTENDING PHYSICIAN: The low requires the Page 4 may be retained by the hospital or attending physicion. DUE TO signed ! buriol. Conditions, if any, which gave rise to immediate cause (a). DUF TO stoting the underlying couse has been be detached for use as the State Dept. of Health prior to last 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO YES certificate 20g. ACCIDENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING I CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (County) (State) Nat While factory, street, office bldg., etc.) at work 4/14/47, 19_, that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. 117140,19 and that death accurred at 12 30 PM, from causes and on the date stated above. DIRECTOR: saw the deceased alive on. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING director, page 3 should be filed v M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S FUNERAL NAME (Type) 23o. BURIAL, CREMATION, 23b. DATE THEREO! 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) CREEK 0 FUNERAL DIRECTOR 256 RESISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY h. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b write RURAL and give nearest town) completely filled by e-carbon papers. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET e. IS RESIDENCE ON A FARM? 24 69 PENNA, AU NO P within 3. NAME OF First Middle Last DATE Month Year DECEASED OF DEATH 196 (Type or print) executed 5. SEX DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR last birthday) | Months | Days IF UNDER 24 HRS remov n any Months Days Hours WIDOWED DIVORCED [10a. USUAL OCCUPATION (Cive kind of work done | 10b. KIND OF BUSINESS OR physician n please r val, and in 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? pe during most of working life, even if retired) INDUSTRY CLOTH death certificate FATHER'S NAME attending phy srmit. Then p n, or removal, MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITYNO. MME (Yes, no, or unkown) [(If yes give war or dates of service) igned by the att rial-transit permirial, cremation, c NO 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: PHYSICIAN: The law requires that the top hospital or attending physician. IMMEDIATE CAUSE (a) been signed the burial-tr or to burial, (**DUE TO** Cenditions, If any, which (b) gave rise to Immediate DUE TO cause (a), stating the has be as th prior underlying cause last. 2220 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED WAS AUTOPSY for use Health PERFORMED? certificate CAT YES Z NO CERTIF 20a, ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B.) etached Dept. of OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) CAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm,) 20f. (City or town) (County) (State) factory, street, office bidg., etc.) o o MEDI Hour a.m. After Not While OR ATTENDING I be Stat at work at work the S 104-27 21. I certify that (1) (this hospital) attended the deceased from Oct./~ 1965 .. 194 7, that (I) (we) last DIRECTOR: age 3 should iled with the 1967, and that death occurred at 300 M, from the causes and on the date stated above. saw the deceased alive on 4 - 2 G 22a. SICNATURE 22b. DATE SICNED page ATTENDING PHYS. -28-6 M.D. Page 4 may DIRECTOR director, pa PHYSICIAN'S ADDRESS NAME (Type) BURIAL, CREMATION. 23b. NAME OF CEMETERY OR CREMATORY LOCATION (State) 23d. (City, town or county) 2 REMOVAL (Specify) **FUNERAL DIRECTOR** ADDRESS REC'D BY RECISTRAR RECISTRAR'S SIGNATUR 25b. VR A15 (4) 1/65



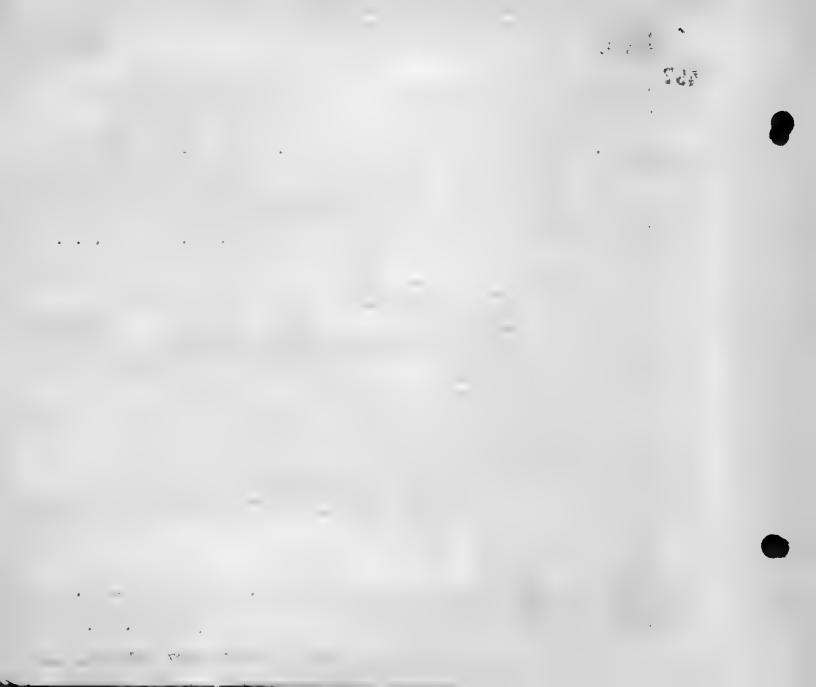
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04972 CERTIFICATE OF DEATH PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. completely filled in by the funeral documents. Pages 1 and yevent, within 72 hours after deat PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased fixed, if institution: Residence before admission) a. COUNTY . . o. STATE 6 COUNTY Carrobl MARYLAND Maryland Baltimore 6ity b. City OR TOWN (If autside carparate limits, c CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 write RURAL and give nearest town)
Sykesville years Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 61 E. Randall Street YES NO NAME OF Middle 4 DATE First rast Manth Year DECEASED Pearl Jacobs Callender 67 (Type or print) DEATH 19 SEX 6 COLOR OR RACE 9 AGF (In years 1 YEAR IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED DATE OF BIRTH last buthday) Months Days Haurs 03-04-92 Female White WIDOWED DIVORCED 00) rem signed by the attending physician and burial-transit permit Then please rem buriol, cremation, or removol, and in on 10a. USUAL OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State, or foreign country) 1Db KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working the even if ret red)
Housewife U.S.A. AT HOME Maryland, Baltimore 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Morris Jacobs Marv 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na., ar unknown) (If yes give war or dates of service) 16 SOCIAL SECURITY NO 17. INFORMANT Med. Record 220-54-667151 Springfield Hospital, Sykesville, Md. NTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c),) PART I. DEATH WAS CAUSED BY ONSET AND DEATH Cardiac failure days IMMEDIATE CAUSE (6) DUE TO Metastatic carcinoma of the liver due to Conditions, if any, which gave years (b) ase to immediate cause (a). DUE TO stating the underlying cause Old breast cancer Page 4 may be retained by the hospital or attending O FUNERAL DIRECTOR: After this certificate has been significant, page 3 should be detached for use as the I should be filed with the State Dept. of Health prior to be last. years PART I! OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) WAS AUTOPSY PERFORMED? Schizophrenic Reaction, Paranoid type. NG YES 200 ACCIDENT WAS UNDERLYING [1] 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Day, Year Haur o.m. 2Dd INJURY OCCURRED 2De. PLACE OF INJURY (Hame, farm, (City or tawn) (County) (State) factory, street, affice bldg., etc.) Not While at wark at wark 21. 1 certify that (1) (this haspital) attended the deceased fram 6-25-29 4-27 1967, that (we) last . 19 . ta saw the deceased alive an April 27 19 67, and that death accurred at 12: 45 M, from causes and an the date stated above 22a SIGNATURE 22b. DATE SIGNED MED. DIRECTOR STAFF PHYS. **ATTENDING** 52 M.D. 4-27-67 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Naci Buyukunsal, M.D. Springfield Hospital. Sykesville, Md. 23a. BURIAL, CREMATION, 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (State) (County) REMOVAL (Specify)
BURIAL BALTIMORE, MARYLAND OHEB SHALOM 4/28/67 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE VR A15 (4) SOL LEVINSON & BROS. INC. 6010 REIST. RD. DATEMAY Microsto, Judge

MARYLAND STATE DEPARTMENT OF HEALTH

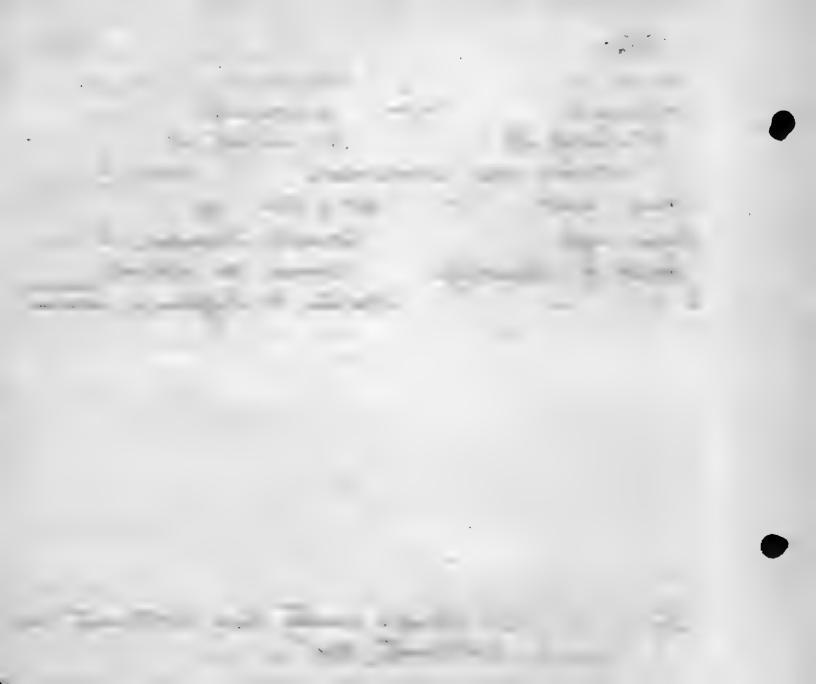


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W, PRESTON STREET, BALTIMORE 1, MARYLAND OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where decressed lived, if institutions Residence before adm ssion) B. COUNTY STATE b. COUNTY MARYLAND Carroll Marvland CITY OR TOWN III outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits. c LENGTH OF STAY IN 16 write RURAL and give nearest town? Westminster

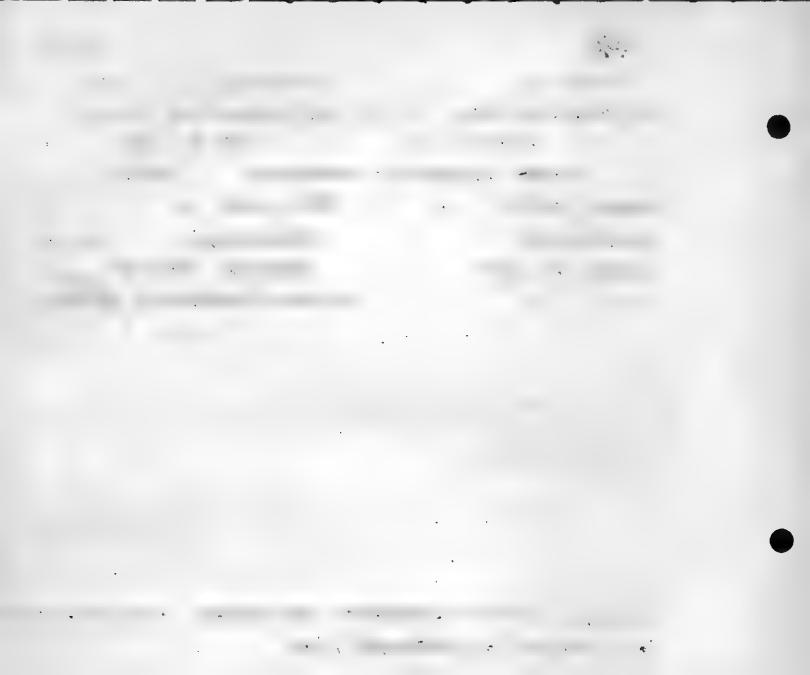
d. NAME OF HOSPITAL OR INSTITUTION (II not in hospital, give streat address) d. STREET ADDRESS inster IS RESIDENCE ON A FARM? YES NO. Green St. 3. NAME OF Middla DECEASED (Type or print) 19 67 CORBIN and col 5. SEX 6. COLOR OR RACE T MARRIED NEVER MARRIED 9. AGE (In years IF UNDER I YEAR DATE OF BIRTH IF UNDER 24 HRS. last birthday) | Months | Days Hours Male WIDOWED IX DIVORCED 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State, or foreign country) 1 12. CITIZEN OF WHAT COUNTRY? done during most of working tife, even if retired) U.S.A. Real Carroll Co. Md. Estate Broker 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME lliam L. Florence Yingling Corbin 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 1 17. INFORMANT (Yes, no, or unkown) | (If yes give war or dates of service 18. CAUSE OF DEATH [Enter only one causa per line for (a) (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 15 74 Conditions, if any, which gave rise to immediate cause **DUE TO** (a), stating the underlying causa fast. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(*) 19. WAS AUTOPSY PERFORMED? NO Z 200. ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURED. (Enter paters of injury in Port I or Part II of tem 18.) OR CONTRIBUTING CAUSE OF DEATH LIF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, Jarm. (State) Month, Day, Year 20f. (City or fown) (County) No While fectory, street, office bldg. Fatc 1 While Hour a.m. al work at work 21. I certify that (I) (this hospital) attended the deceased from and that death occurred at M, from the causes and on the date stated above. saw the deceased alive on 22b. DATE 22a. SIGNATURE ATTENDING /SIGNED STAFF DIRECTOR PHYS. 224. PHYSICIAN S 22d. ADDRESS NAME (Typa) James Saffe Main St. Reisterstown. Md. 23a. BURIAL, CREMATION, 236 DATE THEREOF 23d. LOCATION (City, fown or county) REMOVAL (Spacify) 5 0 Bur i al Meadow Branch Carroll Co. Md. 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before edmission) MARYLAND c. LENGTH OF STAY IN 16 outside corporete limits, write RURAL and give neerest town) TOWN (if outs'de corporale limits. RURAL and give nearest town NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address IS RESIDENCE ON A FARM? YES NO P J. NAME OF M.ddle Month DECEASED (Type or print) DEATH 196 1 8. DATE OF BIRTH IF UNDER 24 HRS. AGE (In years | IF UNDER I YEAR NEVER MARRIED last birthday) Months DIVORCED [WIDOWED Z USUAL OCCUPATION (Give kind of work 8 RTHPLACE (County & State, or top gn country) 12. CITIZEN OF WHAT COUNTRY? 10b. KIND OF BUSINESS OR INDUSTRY during most of working lefe, eyen if retired) 13. FATHER'S NAME SECURITY NO. no, or unkown) (Hyes give wer or dates of service) 18. CAUSE OF DEATH |Enter only one cause per line for .e) (b) and (c). ONSET AND DEATH Some weens IMMEDIATE CAUSE (a) DUE TO Conditions, if eny, which gave rise to immediata cause DUE TO (a), stating the underlying PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NO RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 1 19, WAS AUTOPSY PERFORMED? NO Z 206. ACCIDENT WAS UNDERLYING ____ 20b. DESCRIBE HOW INJURY OCCURED. Enter neture of noury in Port I or Port I of Item 18.)
OR CONTRIBUTING [] CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 20f. (C'ty or fown) (State) .County) 20c. TIME OF INJRY Month, Dev. Yeer fectory, street, office bldg., etc.) Not While While et work et work 21. I certify that (I) (this hospital) attended the deceased from Island 4 24 ", 1967, to R. J. S. 4., 1967, that (I) (we) last saw the deceased alive on the 226. DATE 22e. SIGNATURE ATTENDING SIGNED Z--DIRECTOR PHYS. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type 23c. NAME OF CEMETERY OR CREMATORY 256. REGISTRAR'S SIGNATURE AREC'D BY REGISTRAR VR A15 (4) 15M 7 61



_ 1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND								
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rs after death by the uneral Pages I and J us after death	1. PLACE OF DEATH a. COUNTY b. COUNTY D. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission b. COUNTY D. COUNTY MARYLAND C. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)								
24 hour filled in papers.	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) A course of Hospital or Institution (if not in hospital, give street address) Course of Hospital or Institution (if not in hospital, give street address)								
complete	OECEASED (Type or print) LAURA BURNETTE DRECHSLER DEATH APRIL 20 1967								
be exection and cian and ase remote in any of the contraction and the contraction and the contraction and the contraction are contractions.	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED								
ertificatuling phy	JOHN G. ELY BERTHA BOLTE								
death certificate e attending physi permit. Then ple ion, or removal, a	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address SAINE (Yes, no, or unkown) (If yes give war or dates of service) LESTER E-DRECHSLER ADDRESS								
ding physician. been signed by the the burial-transit to burial-transit or to burial, cremain	18. CAUSE DF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								
CIAN: The Sspital or certificate ned for us	PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
NG PHYSI by the hofter this be detact	ZDc. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4								
O HOSPITAL OR ATTENDING Page 4 may be retained by the Funeral director. After director, page 3 should be should be filed with the State	21. I certify that (I) (this hospital) attended the deceased from 1957, 19 to appeal 9 19 6 7 that (I) (we) las saw the deceased alive on 1921/919 67, and that death occurred at 330 M, from the causes and on the date stated above 22a. SIGNATMRE 22b. DATE SIGNED ATTENDING MED. STAFF PHYS. 12c. PHYS. 12c. PHYS. 12c. ADDRESS MAME TYPES. 12c. PHYSICIAN'S AMEDITARY AND STAFF PHYS. 12c. ADDRESS MAME TYPES. 12c. ADDRESS Learner AND AND STAFF PHYS. 12c. PHYS. 12c. PHYS. 12c. ADDRESS Learner AND AND STAFF PHYS. 12c. PHYS. PHYS. 12c. PHYS. PHYS. 12c. PHYS. PHYS. 12c. PHYS. PHYS. 12c. PHYS.								
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		MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND								
FOR STATE		04976 MEDICAL EXAMINER'S CERTIFICATE OF DEATH								
HEALTH DEPT.	1.	a political desired that are a second that the								
1 E V 3 2		CARROLL MARYLAND B. COUNTY CARROLL								
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esss traffunces 5 may Departma	-	UNIONTOWN MINUTES UNIONTOWN								
Page Bours af)	d. NAME OF HOSPITAL OR INSTITUTION (If not In hospital, give street address) d. STREET AODRESS e. IS RESIDENCE ON A FARM?								
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AMIL the cert should should files. CTOR: Pa designate		death resulted from: Natural causes Accident X, Suicide , Homicide , Undetermined manner								
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Dan 5 5	$\frac{2}{2}$	BURIAL Specify) 4/4/67 PIPE CREEK CARROLL CO MD 4. FUNERAL DIRECTOR 250 ADDRESS 250 REC'D BY REGISTRAR 250 APGISTRAR'S SCONATURE.								
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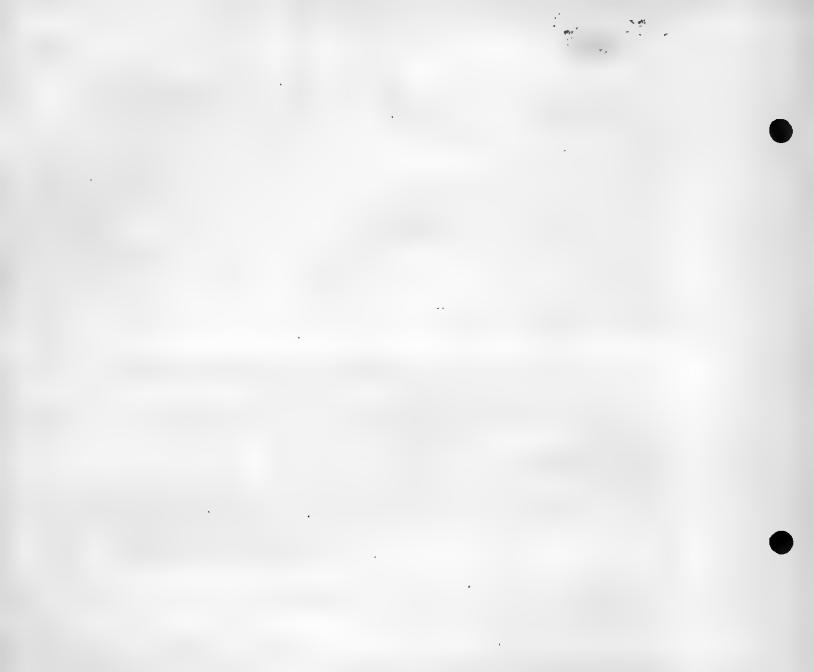
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH uneral and 2 death, PLACE OF BEATH USUAL RESIDENCE (Where deceased lived, if institution: b. COUNTY MARYLAND c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b write BURAL and give nearest town) rbon papers. , within 72 ho e. IS RESIDENCE ON A FARM? d. STREET ADDRESS filled NO C YES letely executed within DATE DF DEATH 3. NAME OF Day 4. DECEASED car 19/2 (Type or print) AGE (In years | IF UNDER 1 YEAR IIF UNDER 24 HRS. SEX DATE OF BIRTH NEVER MARRIED remove 7. MARRIED last birthday) Months I Davs Hours any WIDOWED DIVORCED YES. 12. CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work done) 10b, KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) ase during most of working life, even if retired) death certificate be гетоуа attanding premit. Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT 17. transit permit. cremation, or r (Yes. no. or unknwn) | (If yes give war or dates of service) the INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). The law requires that the I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) been signed burial. burial, DUE TO Conditions, If any, which rise to immediate 書き DUE TO (a), stating prior 1 underlying cause last. 88 CERTIFICATION WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) r This certificate hetached for use te Dept. of Health for use Health PERFORMED? NO 🗔 YES [PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,) 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) After could be the state Hour a.m. Not While at work While at work 19 p.m. attended the deceased from 21. I certify that (i) (this hospital) DIRECTOR: Jage 3 should lied with the and that death occurred at 5 15 M, from the causes and on the date stated above. saw the deceased alive on DATE SIGNED ATTENDING STAFF M.D. DIRECTOR E = HOSPITAL ADDRESS FUNERAL director, p 23d. LOCATION (City, town or county) NAME OF CEMETERY OR CREMATURY CREMATION, 23b. DATE THEREOF 23a. 2 REMOVAL (Specify) REC'D BY REGISTRAR REGISTRAR'S SIGNA FUNERAL DIRECTOR 196 A15 (4)

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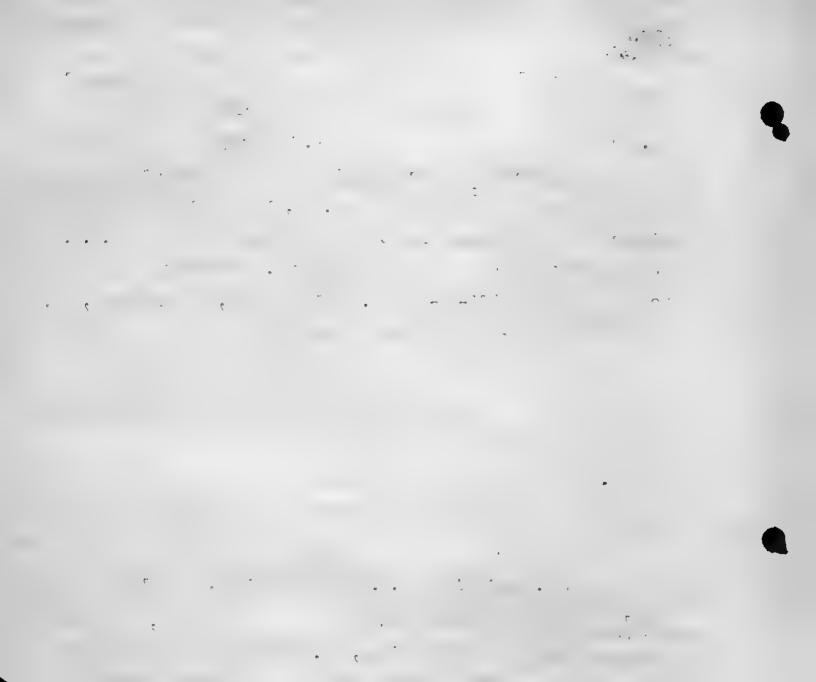
RESTON STREET, BALTIMORE 1, MARYLAND 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where dancesed lived, if Institution: Residence before edmission) a. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits OR TOWN (If outside corporate limits, write RURAL and give nearest write RURAL and give nearest town) d. NAME OF HOSPITAL INSTITUTION (if not in hospital, give street address d. STREET ADDRESS . IS RESIDENCE ON A FARM? YES NO 1 Main Street NAME OF DATE Month DECEASED OF (Type or print) DEATH 196 5. SEX AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 7. MARRIED THEVER MARRIED pue last birthday) Months WIDOWED 1 DIVORCED T physician 10b. KIND OF BUSINESS OR INDUSTRY 1 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAM 15. WAS DECEASED EVER IN U.S. ARMED FORCES? SOCIAL SECURITY NO. 1 17. INFORMANT (Yes, no, or unkown) | lifyes give were relates of service 18. CAUSE OF DEATH [Enter only one cause par line for (a), (b), end (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which {b} gave rise to immadiate cause DUE TO (a), stating the underlying cause fast. PART II. OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) 1 19. WAS AUTOPSY PERFORMED? NO Z CERTIFIC 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of nury in Part I or Part I of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WEDICAL 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20. PLACE OF INJURY (Homs, farm. 20f. (City or town) (County) (Stata) factory streat, offica bldg , atc.) Hour a.m. Whila Not While at work at work p.m. saw the deceased alive on 196.7., and that death occurred attack M from the cause's and on the date stated above. 22a. SIGNATURE DATE ATTENDING SIGNED DIRECTOR PHYS M D FUNERAL 22c. PHYSICIAN S ADDRESS NAME (Type) 23a, BURIAL, CREMATION, | 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (Stata) Burial (Specify) Sandymount Cemetery Sandymount. Carroll 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a, REC'D BY REGISTRAR 25b, REGISTRAR'S SIGNATURE VR A1S pton - Eline Funeral Home Hampstead. Md.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04979 CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. SIATE aryland o. COUNTY Carroll MARYLAND requires that the deoth certificate be executed within 24 hours often b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURA; and give nearest tawn) write RURAL ond give negrest town) Month Rural-woodbine d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Co. General Tospital R.D. Florence YES NO IS NAME OF Middle First Lost 4 DATE Dov Year DECEASED ROSE F. 3 Type or print DEATH 1 YEAR S SEX IF UNDER IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH 9 AGE (in veors Ф rlast birthday) Days Hours Sent. 70 470 Viite WIDOWED DIVORCED 6.1912 puo 10o USJAL OCCUPATION (Give kind of work done TOD KIND OF BUSINESS OR 1) BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY ? INDUSTRY Politimore City J. S. A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, signed by the ottending phy Joseph Swiston Pauline | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO Address -transit permit, cremotion, ar re (Yes, no, or unknown) (If yes give wor or dates of service) 6-03-1766 Ir. Ray ond O. Fleming Jone As 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave use to immediate cause (a). DUE TO storing the underlying couse hos been lost PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) WAS AUTOPS PERFORMED? O FUNERAL DIRECTOR: After this certificate YES 🗔 NO 205. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Dov. Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While Hour om foctory, street, office bldg , etc.) at work 21. I certify that (1) (this hospital) attended the deceased from 13, 1962, that (1) (we) last 3/27 . 19 67. ta 4//3 1967, and that death occurred at 7 20 M, from couses and on the date stated above saw the deceased alive on, 220 SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS director, page 3 should be filed w M.D. PHYS DIRECTOR 22d. ADDRESS PHYSICIAN S NAME (Type) Vincent Mocco West: inster. Ad 23b. DATE THEREOF 23c NAME OF CEMETERY OR CHEMINA 23d LOCATION (City or Town) 230 BURIAL CREMATION. REMOVAL (Specify) Chane. Carroll organ 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) Sylesville, Ild. 20 M 1/66



RYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAR CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before edmission) a. COUNTY b. COUNTY Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, c CITY OR TOWN (If outside corporate limits, write RURAL and give neerest town) c. LENGTH OF STAY IN 16 write RURAL and give necrest town) Union Bridge Union Bridge vears d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? Broadway E. Broadway YES NO X 3. NAME OF DATE Month Year DECEASED (Type or print) Hunter DEATH 67 Gardan Fogle 19 April 6. COLOR OR RACE 7. MARRIED TO NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years I IF JNDER I YEAR IF UNDER 24 HRS lest birthdey) WIDOWED **DIVORCED** male physician Ige. USUAL OCCUPATION (Give kind of work 106. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or fore gn country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Cement Plant Maryland Engineer 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please Mary C. Flickinger John Wesley Fogle 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16 SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) | (If yes give we ror detes of service) A. Pauline Fogle, Union Bridge, Md. no 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: athorn sclerosis early IMMEDIATE CAUSE (e) **DUE TO** Conditions, if any, which gave rise to immediate cause DUE TO (e), steting the underlying cause lest. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a), 19, WAS AUTOPSY PERFORMED? them overkage 200, ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part It of Item 18.) OR CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f (City or town) (County) (Steta) factory, street, office bldg., etc.) While Not While Hour e.m. et work et work 21. I certify that (I) (this hospital) attended the deceased from 923.64... 4.7....., 19....., that (I) (we) last 19. . 19. , and that death occurred at 2NR, from the causes and on the date stated above. saw the deceased alive on 220. SIGNATURE 20 b. DATE ATTENDING STAFF SIGNED **PHYS** DIRECTOR PHYS. M.D. 22c. PHYSICAN'S 22d. ADDRESS NAME (Type) Union Bridge, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, lown or county) 230. BURIAL CREMATION, (State) Lutheran Cemetery Uniontown. ADDRESS DIRECTOR'S SIGNATURE Union Bridge, Md.

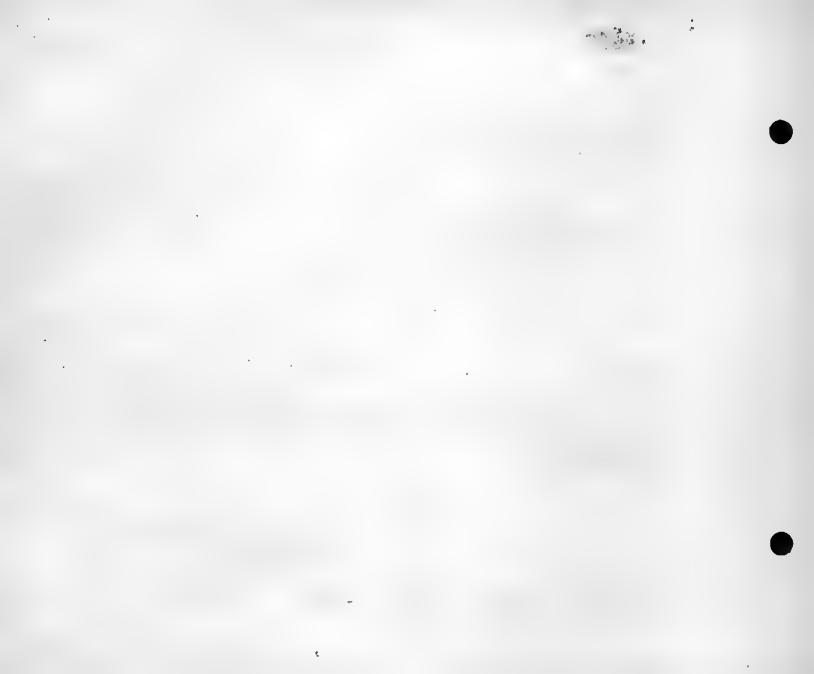


4 . *	MARYLAND STATE DEPARTMENT OF HEALTH						
	12	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
FOR STA	TE	04981 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04981					
HEALTH D	EPT.	1. PLACE OF BEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)					
		e. COUNTY CARROLL MARYLAND B. STATE MARYLAND COUNTY CARROLL					
eral be be	age	b. CITY OR TOWN (If outside corporate limits, c. LENGTH DF STAY IN 1b c. CITY DR TOWN (If outside corporate limits, write RURAL end give nearest town)					
recessar he funer 5 may b	- de	WESTMINSTER DOM UNION BRIDGE					
y is recessar; to the funerage 5 may b	after death.	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?					
Pag 3 trate	hours	DOA CARROLL CO GENERAL HOSPITAL 205 MAIN ST YES NOW					
and 3.	g	3. NAME OF First Middle Last 4. DATE Month Day Year DECEASED OF OF OR A COLUMN (ATT					
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Page h fo		DIVORCED DEC 16 - 1941 25 yrs. 10a. USUAL OCCUPATION (GIVe kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT					
ter d Sive S wit		during most of working life, even if retired) INDUSTRY					
aft.	-	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME					
ours af m 18. l e along pages	[.E	CLAUDE E FORNEY EDITH REESE					
74 ho Iter Office	and	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address					
AL EXAMINER: This certificate should be executed within 24 hours after death. If any delthe certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and should be forwarded to the Chief Medical Examiner's Office along with form PM3. If files.	removal,	(Yes, no, or unknown) (If yes give war or dates of service) 218-38-3891 CELINE FORNEY UNION BRIDGE					
witi pend nine	iem i	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
rted ' in Exan	cremation, or	PARY I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE OF: PARY I. DEATH WAS CAUSED BY: THE TOP (B) (B), MID (C). III					
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	io t	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES NO S PRIMARY 50 or CONTRIBUTING THE CAUSE WAS PRIMARY 50 or CONTRIBUTING THE CONTRIBUTION THE CONTRIBUTION OF THE CONT					
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te, Th	gent	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED, 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) **Rour 4-74/ 1967 at work Not While at work Accuses well fell union Bridge Carrolf Mid					
NER iffica be f	200						
S. P.	designated	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection XI, Inquiry, and in my opinion					
the ce	lesig	death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner ,					
	ts	ACTUAL // 19/2 ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED					
Xecu Pag for)	, 0	DEPUTY MEDICAL EXAMINER X					
DEPUTY MEDIO please execute director. Page ' fetalned for your	of Health	RAMINER'S /W GLENN SPEICHER decreed (Street, Steller or Identity) Tiller stick in youl					
O DEPUTY please ex director. retained	1 H	233. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county)					
5 2 2 5	300	TREMOVAL (Specify) 4-17-67 WINTERS NEW WINDSOR DID 24. FUNERAL DIRECTOR ADDRESS 258. REGID BY REGISTRAR 256. REGISTRAR'S SIGNATURE					
UD A151	ME (3)	DIOTI TO DILLINGS APR 18 1967 Charles Judge					
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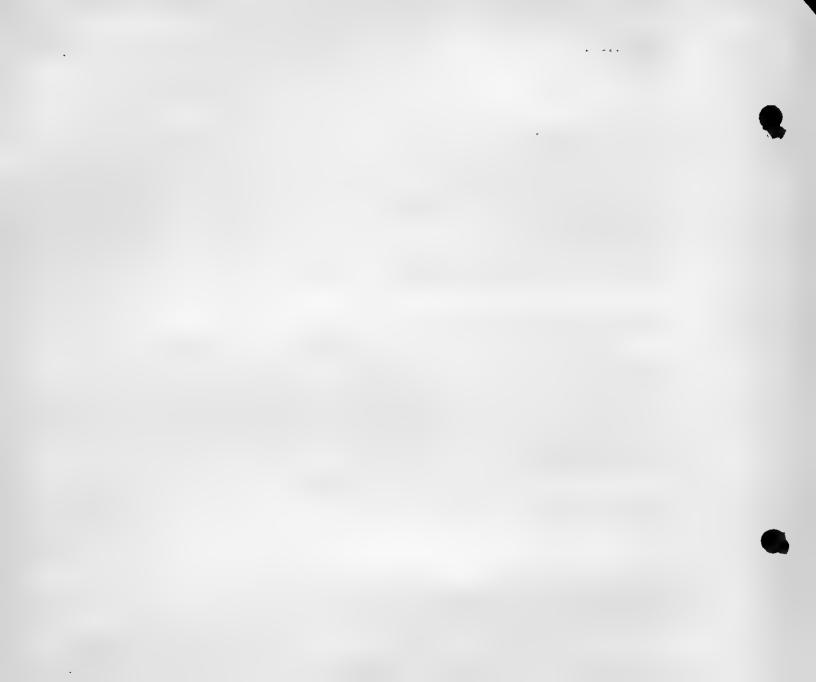


	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
÷ 75	04982 CERTIFICATE OF DEATH	04982				
	PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived,	if institution- Residence before admission)				
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afte afte	b CITY OR TOWN (If gutside carparete timits. c LENGTH OF STAY IN 1b c. CITY OR TOWN (If gutside carparete limits.					
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in b	d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) d STREET ADDRESS	e IS RESIDENCE ON A FARM?				
24 aper i aper n 72	R.D. 6	YES NO				
	3. NAME OF First Middle Last 4 DATE	Month Day Year				
PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death is haspital ar attending physician. The death is certificate has been signed by the attending physician and campletely filled in by the funeral stacked for use as the burial-transit permit. Then please remain barbon papers. Pages 7 and 20 Dept. at Health priar to burial, cremation, or remaval, and in any event, within 72 hours after team.	DECEASED (Type or print) ALOS R. GART BLL DEATH	April 75. 1967				
de (de la	5 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 18, DATE OF BIRTH 9. AGE (III	years IF UNDER YEAR IF UNDER 24 HRS				
exect and day	linle White Widowed Divorced Dec. 18,1889 77	rthday) Months Days Hours Min				
and and in an	10g. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign county &	ntry) 12 CITIZEN OF WHAT				
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Phy ava	Aaron Gartrell Elizabeth ?					
ing Fem	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, ng., or unknown) [(If yes give war or dotes of service)] 17. INFORMANT	Address				
equires that the death certificate be exphysician. signed by the attending physician and burial-transit permit. Then please refound, crematian, or remaval, and in an	(Yes, no, or unknown) (If yes give war or dotes of service) 705-10-3655 Mrs. Orlando Farver	3.D. Mt. Airv. 1				
he c per jan,	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	INTERVAL BETWEEN				
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litte	lost. (c)					
IAN: The law re call ar attending frate has been of far use as the freath priar tab	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART	RT I(a) 19. WAS AUTOPSY PERFORMED?				
문문 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등	20g ACCIDENT WAS UNDERLYING 20g ACCIDENT WAS UNDERLYING 20g CONTRIBUTING CONTRIBUTING 20g ACCIDENT WAS UNDERLYING 20g ACCIDENT	YES NO X				
d a d a far far far Hec	206 ACCIDENT WAS UNDERLYING [2] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of ite	m 18.)				
SIC Serii: Spirit	GR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
JING PHYSICIAN: The Taw requires the by the haspital ar attending physician. After this certificate has been signed by be detached for use as the burial-transtate Dept. af Health priar ta burial, cre	20c. TIME OF INJURY Manth, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, 20f (City or	r tawn) (Caunty) (State)				
5	Hour o.m. 19 While that While of wark	i				
by Affrer Stat	21. I certify that (I) (this haspital) attended the deceased from 7/1 1965, to 7/					
ATTEND Stained CTOR: A shauld ith the	saw the deceased alive an 125 1967, and that death accurred at 1054. M, from					
OR ATTENDING be retained by th NRECTOR: After e 3 should be de ed with the State	220. SIGNATURE ATTENDING MED. SI	TAFF 22b DATE SIGNED				
De le se d'y Re ed v	M.D. PHYS. DIRECTOR P	HYS. D 7/26/67				
Pog Pog e Efficient	22c. PHYSICIAN S Julius Chepko 22d. ADDRESS 851 W. G. Westminst.	reen, St.				
SPII 4 m 4 ER 1d b		er, Ed.				
Page 4 may be retained by the haspital ar attending FO FUNERL DIRECTOR: After this certificate has been director, page 3 should be defacthed far use as the shauld be filed with the State Dept. of Health prior to	23d BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY BROWNERS (23d LOCATION (
5 5 5 2 W	Burian 4/28/1967 Morgan Chanel A. Jamro					
VR A15 (4)	24 FUNERAL DIRECTOR ADDRESS 250. REC'D BY REGISTRAR C. M. Waltz Bo x 241 Sykesville	2Sb REGISTRAR'S SIGNATURE				
20 M 1/66	C. M. Waltz Bo x 241 Sykesville, 14. DARDE 9 2 1967	Icharles Judge				

MAKTLAND STATE DEPARTMENT OF HEALTH



death.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04984 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, function). Residence before admission CARROLL a. STATE **b** COUNTY 3 to Page Pennsylvania MARYLAND delay b CITY OR TOWN (If outside corporate mits, write RJRAL and give nearest tawn)
WESTMINISTER c CITY OR TOWN (If outs de corporate limits, write RURAL and que nearest town) E LENGTH OF STAY IN 16 Shippensburg d NAME OF HOSPITAL OR INSTITUTION (It not in hospital, give street address) d STREET ADDRESS B IS RES DENCE ON A FARM? the State Dep Office alang with farm 36 West King Street CARROLL COUNTY GENERAL HOSPITAL YES □ NO [8. Give Pages NAME OF First Midd e 4 DATE Doy Year DECEASED 1967 WAYNE Franklin HAMMOND 25 (Type or print) DEATH IF UNDER 24 HRS 9 AGE (n years 6 COLOR OR RACE 7 MARRIED X NEVER MARRIED B DATE OF BIRTH lost byrthdoy) Jaly 26, 1907 Hours White WIDOWED DIVORCED Male Item] l and 2 within 72 hours after dea 180 USUAL OCCUPATION (Give kind of work done 10b K ND OF BUSINESS OR 11 BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT during most of working life, even if ret red)
Us topath NDUSTRY COUNTRY? Spring Run. Pa. snauld be farwarded to the Chief Medical Examiner's 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME be executed with;n Franklin Wolff Martin Hammond Mary Ann IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor at dotes of service Mrs. Emma Hammond same address INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I, DEATH WAS CAUSED BY burial-fransit ONSET AND DEATH in any event Arteriosclerotic cardiovascular disease MMED ATE CAUSE (o) This certificate shauld writing the ward 4221 DUE TO Conditions, if any, which gave (b) rise to immediate couse (a), DUE TO stating the underlying cause O and and WAS AUTOPSY PERFORMED? be used PART II OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) crematian, or remayal, CERTIFICATION YES X execute the certificate, NO 20o EXTERNAL CAUSE WAS 20b DESCR BE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of Item 18) 3 should PRIMARY I or CONTRIBUTING I MEDICAL EXAMINER: CAUSE OF DEATH MEDICAL 20c TIME OF NURY Month, Day, Year 70rt N.JRY OCCURRED 20e PLACE OF INJURY (Home form, (City or fown) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While DIRECTOR: Page at work ot work 21. I certify that I taak charge of the remains described above, held an Autopsy [X]. Inspection . Inquiry [], and in my apinian Notural causes XX Accident death resulted fram-Suicide Hamicide Undetermined manner funeral directar be retained CHIEF MEDICAL EXAMINER 22. DATE SIGNED 5 may be refu TO FUNERAL DI Health priar t ASSISTANT MED CAL EXAM NER DEPUTY MEDICAL EXAMINER 4-25-67 WERNER U. SPITZ M.D. Address (Street, city, town, or county) NAME (Type) the 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF (County) 230 BURIAL CREMATION (State) Shippensburg 4/29/1967 Spring Hill Cemetery 250 REC D BY REGISTRAR 25b REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR VR A15ME (5) 6M 1/67



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND hours after death. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) 1. PLACE OF DEATH a. COUNTY b. COUNTY Carroll Maryland Carroll MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 30 YRS. Finksburg #2 Finksburg #2 e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Kay's Mill Road Kay's Mill Road YES NO C completely i executed within 3. NAME OF Middle Month Oay Year First OF DEATH DECEASED 19 (Type or print) and compl AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months | Days | Hours | Min. 5. SEX 5. COLOR OR RACE OATE OF BIRTH 7. MARRIED NEVER MARRIED white female WIDOWED DC DIVORCEO 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done | 10b, KIND OF BUSINESS OR physician COUNTRY? during most of working life, even if retired) INDUSTRY U.S.A. housewife Baltimore death certificate 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME removal Harasha Nelson Justice Carrie E. Hardyshell 15. WAS OFCEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY-NO. transit permit. Brodberha (Yes, no, or unkown) | (If yes give war or dates of service) Howard 7 INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH | Enter only one cause per line for (a), (b), and (c), been signed by the the burial-transit or to burial, cremati PART I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCIEROTTE CARDIOVASCILAR DISERSA Conditions, if any, which gave rise to immediate DUE TO cause (a), stating the prior underlying cause last. certificate has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) WAS AUTOPSY PERFORMEO? CERTIFICATION for use Health NO [YES 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING OF CAUSE OF OFATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) (State) MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Oay, Year factory, street, office bidg., etc. Hour a.m. Not While at work at work FUNERAL DIRECTOR: Afficiency, page 3 should be filed with the S be retained 19/707 to UAN / 19/7 that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from 19 67, and that death occurred at 6 % M, from the causes and on the date stated above. LAN 11 saw the deceased alive on 22b. OATE SIGNEO 22a. SIGNATURE **OIRECTOR** PHYS. M.D. PHYS. 22d. A OOR ESS director, pr PHYSICIAN'S NAME (Type) 23d. LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION. 23b. OATE THEREOF Kinkaburg #1 REMOVAL (Specify) Maryland Sandymount Cemetery burial April 25b. REGISTRAR'S SIGNATURE ADDRESS FUNERAL DIRECTOR VR A15 (4) 15M 4-64



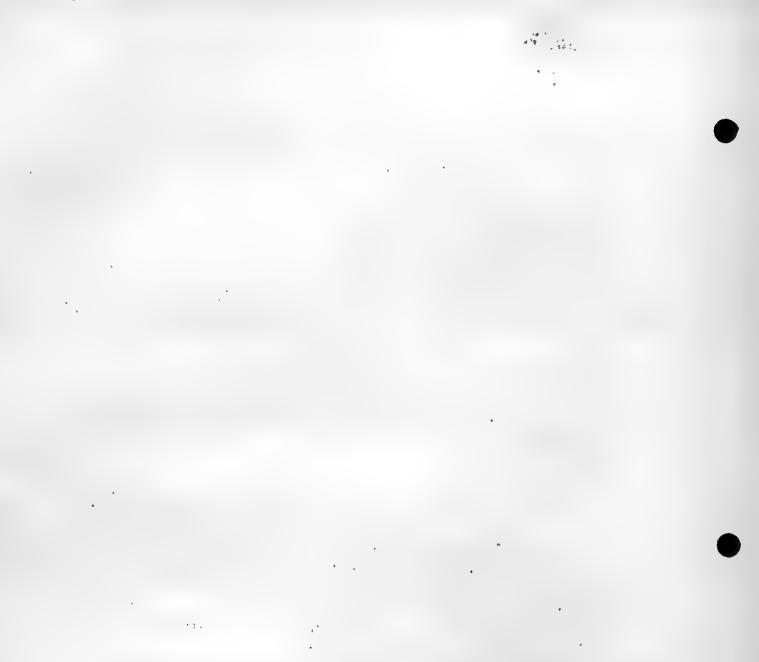
	1	1	Division of STATISTICA	MAKYLAND STATE DEF AL RESEARCH AND RECORDS, 301		E, MARYLAND 21201
7	AA	1	04986	CERTIFICATE	OF DEATH	04986
	funerol sond	7	C. COUNTY AFFOLL	MARYLAND	a. STATE Md.	b. COUNTY CArroll
	hours after deat in by the funero rs. Pages I ond thours after deet		b CITY OR TOWN (If outs de corporate limits, write RURAL and give neorest town).	c. LENGTH OF STAY IN 16 2 Weeks	RUTAL SYKES	ville
	hin 24 hc filled in papers. thin 72 h	^	CAFFOLL CO. GE	N. HospitaL	Mineral Hill	Road e is residence on a farm?
	cuted within 24 ha	L	NAME OF DECEASED (Type or print) John	Clarence H	ARPINE DEATH	April 3, 1967
	and completely compared with	.	Male White V	VIDOWED DIVORCED	2-24-1900 6	(in Jears IF UNDER YEAR IF UNDER 24 HRS. to.rthday) Manths Days Hours Min
	physician and ploose cem		Da USUAL OCCUPATION (Give kind of wark dane uring most of working life, even if retired) A C A D C 3. FATHER S NAME	10b. KIND OF BUSINESS OR UDUSTRY	33 BIRTHPLACE (County & State, or fareign VA, 14 MOTHER S MAIDEN NAME	country) 12 CITIZEN OF WHAT COUNTRY?
	rertificang phys		Lemual Harpine S. Was DECEASED EVER IN U.S. ARMED FORCES?		GYNTHIA GOL	liday
	at the death cer the attending p isit permit. The mation, or remo		(Yes, no, prunknown) (If yes give war ar dates of ser	vice) Mi	6	Sykesville, Md.
	PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death in hospital or ottending physicion. It is certificate has been signed by the attending physician and completely filled in by the funeral stacked for use as the buriol-transit permit. Then please tempore corban papers. Pages I operate the office of the other prior to burial, cremation, or removal, and in any event, within 72 hours after death.		IB. CAUSE OF DEATH (Enter only one cause poper of the cause of the part I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). 5 5 10 DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO	Curlos J	The leven	ONSET AND DEATH
	4: The law re or offending ite hos been use os the solth prior to		lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTR	T OT DELETE TOM THE HEAR OF SMETHER	HE TERMINAL DISEASE CONDITION GIVEN IN	DADT 1(a) 19 WAS ALITOPSY
	In The out of out of out		(home (nor	relitin	Enter nature of injury in Part I ar Part II o	YES NO -
	PHYSICIAN: The law right he hospital or offending this certificate hos been letoched for use os the Bopt. of Heolth prior to					y ar tawn) (County) (State)
			Hour a.m p.m. 19	While Nat While of work of the deceased fram	ry, street, office bldg , etc.)	
	OR ATTENDING be retained by the IRECTOR: After a 3 should be d ed with the State		saw the deceased alive an Cig	fril 3, 1967, and that	death accurred at 7 M, fro	m causes and an the date stated above.
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the hospital or ottending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to		27c PHYSICIAN'S V	Gershey M.D	22d ADDRESS	STAFF PHYS. D 4/3/L
	Poge 4 moy OFFINERAL I director, pog should be fil	\	NAME (Type) JOHN 3a BURIAL, (REMATION, 23b. DATE THEREO			N (City or Town) (County) (Stote)
	F- F		PREMOVAL (Specify) 4-5-6	7 Lake View 1	2Sa. REC'D BY REGISTRAR	25b. REGISTRARS SIGNATURE Climber Judge
	VR A15 (4) 20 M 1/66	10	Horry W. Harshit	stykesville Th	C. DATEAPR 1 0 19	24 January July



. 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND.
FOR STATE	04987 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04987
HEALTH DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY b. COUNTY
2.4 0	CARROLL MARYLAND MARYLAND CARROLL
letay is necessary, and 3 to the funeral Page 5 may be State Department hours after death	b. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) write RURAL and give nearest town)
the f	d. NAME OF HOSPITAL OR INSTITUTION (If not in Mospital, give street address) d. STREET ADDRESS 0. IS RESIDENCE
lay is 13 to the Page Page ours at	ON A FARM? YES NO
dela and 3 3. P 3. P 6 Sta	3. NAME OF First Middle Last 4. DATE Month Day Year DECEASEO
2, and PM3. PM3. In the St	(Type or print) WILLIAM FESTER HIGGINS DEATH 4 23 1967
H 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	last birthday) Months Days Hours Min.
with a suppose of the	10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY 1. BIRTHPLACE (State or foreign country) (COUNTRY?
fter (Give g wil	during most of working life, even if retired) INDUSTRY TIMBLE AND LOGICALING FOR PLACE BURNSVILLE N.C. FLOCK.
INER: This certificate should be executed within 24 hours after death. If ificate, writing the word "pending" in pencil in Item 18. Give Pages 1 be forwarded to the Chief Medical Examiner's Office along with forming 3 should be used as a burial-transit permit. File pages 1 and 2 with ed agent, prior to burial, cremation, or removal, and in any event within	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
14 hou Item Office File p	MCN/T HIGG-INS ANNIE RANDOLPH 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Act Consultations
n 24 in 1 s Off t. Fi	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) (If yes give war or dates of service) (HO -34-0366 MPS, MAINT S. HIGH-INC DITTER
I within pencil in miner's permit.	18. CAUSE OF DEATH LEnter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY.
ted v in p in p ixam sit p or re	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORCUERCY TURQUE GOOD GRATH
uld be executed "pending" in if Medical Exar burial-transit cremation, or	DUE TO
be e pend fedic fedic smat	Conditions, if any, which (b) (b)
ould "d "lef h	cause (a), stating the OUE TO underlying cause last. (c) (c)
ficate showing the work of the Chiral used as a to burial,	
ficate the of the use to b	YES NO X
R: This certiff ate, writing forwarded to 3 should be agent, prior	20a. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING COURRED. (Enter nature of Injury In Part I or Part II of Item 18.)
ward houl	
INER: Thi lificate, be forwa age 3 sho	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20f. (City or town) (County) (State) 4 4 4 4 4 4 4 4 4
EXAMINER: certificate nould be fo les. R: Page 3 signated ag	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection X_, Inquiry, and in my opinion
AL EXAMI the certi should I r files. CTOR: Pag designate	death resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner
63 4 5 5	ACTUAL AC
200.0	DEPUTY MEDICAL EXAMINER X
DEPUTY Melease executive processes of the processes of th	NAME (Type) Address (Street Stockers or object)
TO DEPUTY please ex director. retained for FUNERAL of Health	23a. BURIAL, CREMATION, 23b. DATE THEREOF. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 4/26/67 MANGHISTER BAPTIST MANCHE (TER ROLL)
B-a-Ba	24 FINERAL DIRECTOR ADDRESS 253. REC'D BY REGISTRAR'S SYGNATURE
VR A15ME	24. FUNERAL DIRECTOR ADDRESS ADDRESS LEGISTRAL 250 HELD STRATE STANTISTED LATER PR 2 6 1967 Gliantes Judges
3500 4-64	



	DIVISION OF STATISTICAL RES	RYLAND STATE DEPARTI SEARCH AND RECORDS, 301 V	MENT OF HEALTH W. PRESTON STREET, BAL'	TIMORE 1. MARYLAND
4 224	04988	CERTIFICATE OF	DEATH	04988
is a second	1. PLACE OF DEATH a. COUNTY AFFECT			i, if institution: Residence before admission) CAPTOLI
24 hours after death filled in by tine formelal apers. Pages and n 72 hours after death	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sylcesuillo 6. NAME OF HOSPITAL OR INSTITUTION (if not I	1 YeAR	Y OR TOWN (If outside corporate IIIII SY KESUL NO.	its, write RURAL and give nearest town)
24 h filled papers in 72	Pullen Nursina	to me	MAIN St.	ON A FARM? YES NO X
ding physician and congletely fil Then please remove carbon par	3. NAME DF First DECEASED (Type or print) Myrtle	Virginia Hix	Last 4. DATE OF DEATH A	Month Day Year Pril 22, 1967
executed and conference conferenc	5. SEX 6. COLOR OF RACE / MARRI FEMALE Uli, 1-e WIDOW 100, USUAL OCCUPATION (Give kind of work done) 100	ED DIVORCED 4-4	9. AGE (In last birt	thday) Months Days Hours Min.
ysician please , and in	during most of working life, even if retired) 13. FATHER'S NAME	INDUSTRY COME	IRTHPLACE (County & State, or foreign OTHER'S MAIDEN NAME	country) 12. CITIZEN OF WHAT COUNTRY?
certificate iding physi Then ple removal, ai	William Condon	16, SOCIAL SECURITY NO. 1 17. INFORM	Josephine Lon	dddress /
ires that the death cert' physician. signed by the attending burial-transit permit. Th burial, cremation, or rem	(Yes, no, or unkown) (If yes give war or dates of service)	- MR. U	Willie Hipstey-	Sykesville Md. INTERVAL BETWEEN ONSET AND DEATH
that the ysician. gred by the ransit	PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Jesseralized Ca	of breast	ONSET AND DEATH
日 6 6 6 6 日	Conditions, If any, which gave rise to immediate cause (a), stating the DUE TO	a of Preas		7. 17en
(I) (I) (I)	PARTILOTHER SIGNIFICANT CONDITIONS CONTR	IBUTING TO DEATH BUT NOT RELATED TO T	HETERMINAL DISEASE CONDITION GI	VEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO VEN
ospi ceri hed t. of	PARTII.OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CONTRIBU	DESCRIBE HOW INJURY OCCURRED. (E	Enter nature of Injury in Part I or Pa	art II of Item 18.)
G PHY by the er this e deta ate De	ZOC. TIME OF INJURY Month, Day, Year 200 Hour a.m. Wh	ile - Not While - factory, street	NJURY (Home, farm, t, office bldg., etc.)	own) (County) (State)
OR ATTENDIN y be retained b DIRECTOR: Aft gge 3 should b led with the St	21. I certify that (I) (this hospital) atte	nded the deceased from Age	occurred at / i/M, from the c	auses and on the date stated above.
D Se	22c. PHYSICIAN'S CAM CAN	M.D. PHYS	MED. STAF	1 4 75.67
TO HOSPITAL OF Page 4 may by O FUNERAL DIR director, page should be filed	NAME (Type) SQ N/	23c. NAME OF CEMETERY OR CRE	MATORY 1 23d. LOCATION (City, town or county) (State)
101 TO 10 TO	REMOVAL (Specify) 4-27-67 24. FUNERAL DIRECTOR	Springfield Ce	metery Syke:	SUILLE MO
VR AIS (4) 20M 1/65	Harry W. Haight sy	Kesville, Md.	DAT MAY 1 1967	ycuarles Judge.

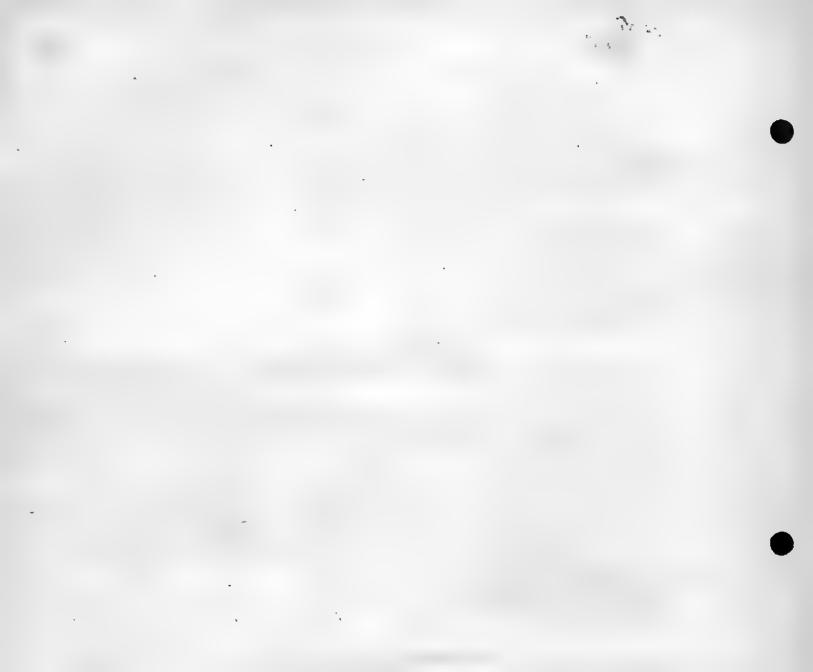


- Aller State of the State of t	1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, M	ARYLAND
- Married St.	i relie	_	PLACE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, 11 institution: Re	04989
	24 hours after death filled in by the fines apers. Pages 1 grann 72 hours after the fill	1.	a. COUNTY 7 1 27 4 1 A CTATE A 4 1 B COUNTY A	esidence before admission)
	Te te	_	b. CITY OR TOWN (if outside corporate limits, c. LENCTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL	Pro //
	Pag Pag Durs		weite DIDAL and give necessit town	kesville. Md.
1	t hou led in ers.	\vdash	d. DAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	9. IS RESIDENCE ON A FARM?
	ithin 24 hours af		Springfield Ave. Springfield Ave	YES NO X
	with upletel	3.	OF (Type or print) NATHAN C. Hobbs, Jr. DEATH April	0ay Year 3 1967
	e death certificate be executed within 24 hour the attending physician and completely filled in t permit. Then please remove Carbon papers. I ation, or removal, and in any event, within 72 hour	5.	Market Mere Market Market Market Market Market Market Market Months	1 YEAR IF UNOER 24 HRS. Days Hours Min.
	exe	10	a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. Cl	ITIZEN OF WHAT
	Sicial Pease		None None Md.	OUNTRY?
	death certificate be ne attending physician permit. Then please tion, or removal, and i	13	FATHER'S NAME	
	cert indin		5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address	
	ulres that the death of g physician. an signed by the attend burial-transit permit. o burial, cremation, or r	ľ	es, no, or unknown) (If yes give war or dates of service) ? MRS. Gertrude Hobbs Su	Kesville, Ned
	ne di the pitt but	=	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
	lat the control of th		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza	
	hysid hysid signa urial- urial-	l	Conditions, If any, which \ D) Myocarditis	4/1/67
	equiring preen		gave rise to immediate DUE TO	<u>through</u> 4/3/67
	aw requi	Z	underlying cause last. (c) Coronary thrombosis and Cardiac Arrest. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a)	19. WAS AUTOPSY
	N: The latal or attained in the second of th	CATIO	PART II, OTHER SIGNIFICANT CONOCITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(4)	PERFORMEO?
	PHYSICIAN: The law requires that the the hospital or attending physician. this certificate has been signed by the detached for use as the burial-transit e Dept. of Health prior to burial, crema	CERTIFICATION	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18. OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	JING PHYSI d by the h After this d be detacl	MEDICAL	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town)	inty) (State)
		MED		
	END! lined Ined ould the		21. I certify that (I) (this hospital) attended the deceased from April 1,, 1967, to April 3,, 1967 and that death occurred at	7, that (I) (we) last
	September 1		22a. SIGNATURE (1) 22b. D.	ATE SIGNED
	AL OR nay be L OIR page filed			i1 3, 1967
	TO HOSPITAL OR ATTENDING Page 4 may be retained by TO FUNERAL OTRECTOR. After director, page 3 should be should be filed with the Stat		22c. PHYSICIAN'S NAME (Type) Howard E. Hall, M.D. 22d. AODRESS Sykesville, Maryland	
	Page Page 10 FU direct	23	Operation of the state of the s	04 /
	- = D	2	DUTIAL 9-6-61 Springfield cometery 34 Kesville,	/VI 'S SIGNATURE
	VR A15 (4) 20M 1/65		Harry W. Height Lykesville, Md. OAPR 10 1967 gelearles	Judge -
	20111 1/00			



. 1			MARYLAND STATE	DEPARTMENT O	F HEALTH	
m 1/		DIVISION OF STATISTIC	AL RESEARCH AND RECO	RDS, 301 W. PRESTO	N STREET, BALTIMO	ORE 1, MARYLAND
1 20	_	04990	Item #2a, 0, 0 & d		0/67 pc	04990
唐言	1.	LACE OF DEATH		2. USUAL RESIDENCE	CE (Where deceased lived, ft 7 b. COUN	natitution: Residence before admission)
# D # .	_	. CITY OR TOWN (if outside corporate I	imits, c. LENGTH OF STAY IN		If outside corporate limits, write	RURAL and give nearest town)
r dan		write RURAL and give nearest town)	, and an	William	01/10/11/ Make	Childy Harry Barry
ges	7	NAME OF HOSPITAL OR INSTITUTIO	(if not in hospital, give street address)	d. STREET ADDRESS	crease	a. IS RESIDENCE ON A FARM?
Jy 55 S. Pa	A	Lary we Juce	my Home	WILL	24441/8/4 Car	lisle St YES NO
plete aper 72 J	31/	Name of Forest Print Forest Print	rst Middle	(an VIII)	OF DEATH Month	2 1-
Com Phin P	5.	1	CE 7, MARRIED NEVER MARRIED	7 8. DATE OF BIRTH	9. AGE (In years	IF UNDER 1 YEAR IF UNDER 24 HRS.
and tarba	Ψ,	Derver Coht	WIDOWED DIVORCED	Gether 19-1	16-64 last birthday)	Months Days Hours - Min.
cian ove even	-10e do	USUAL OCCUPATION (Give kind of was during most of working fife, even if re		OUSTRY 11 BIRTHPLACE (Coun	ity & Stata, or loreign country)	12. CITIZEN OF WHAT COUNTRY?
hysi rom any	12	LATHER'S NAME CATE) gme	Allentow MAIDEN	NAME OF	' US. A
ing in	17	The Les & man	1	Maria	1 Chief	
tend an pl	15.	WAS DECEASED EVER IN U.S. ARMED I	ORCES? 16. SOCIAL SECURITY NO.	17. INFORMANT	2 // Apridress	v. Chestuit 8h
The at		NO	176-05-2009	G.H. Histite	ter Hann	n Pa
ty the real trees	Н	18. CAUSE OF DEATH Enter only : PART I. DEATH WAS CAUSED BY	/ / //	2	11-1	ONSET AND DEATH
hysis part of the same of the	П	IMMEDIATE CAUSE	(a) Curnel	Myreau	deles	-
n sign fran: matic	П		(6) Cilosalinet	Le Cardo	Vosenly Le	elm-
tendi bee urial	Н	gave rise to immediate cause (a), stating the underlying	го			
or at he b	,	CAUSA last.	(e) IDITIONS CONTRIBUTING TO DEATH BU	IT NOT RELATED TO THE TERMIN	NAL DISEASE CONDITION GIV	EN IN PART I(a) 19. WAS AUTOPSY
ficate to to the total	ATTO			~		PERFORMED? YES NO
hosp certif	CERTIFIC	200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING LI CAUSE OF DEA	206. DESCRIBE HOW INJURY OCC	CURED, [Enter natura of injury in	Part I or Part II of Item 18)	
후 등 한 한 한		(IF EITHER, NOTIFY MEDICAL EXAMIN	ER)			
d by Affer ache	DICAL	20c. TIME OF INJURY Month, Day,	White Not While	PLACE OF INJURY (Home, face factory, street, office bldg, etc	n. 20f. (City or town)	(County) (State)
A del	Z	p.m. II	pital) attended the deceased fi	om. Gcl. 20	1954 10 april 5	2, 19 (I) (we) last
PD P		saw the deceased alive on. A	1.11 4	that death occurred at 9	44	and on the date stated above.
Stat		228. SIGNATURE	612	ATTENDING 3	MED, STAFF	22b. DATE SIGNED
4 7 8 7 2 7 8 7 2 7 8 7		22c. PHYSICIANS	Mush.	M.D. PHYS. I	DIRECTOR PHYS.	
Pag vit Pag		HAME (Type) OS Upt	Eloush M	DAMI	かくナをみつ	Mary/and
in the result of	234	BURIAL, CREMATION, 235. DATE 1	HEREOF 230 NAME OF CEME	TERY OR CREMATORY	23d. COCATION (City, but	wn pr county) (State)
နှင့်ခဲ့မှု ရှင်နှင့်	7	FUNERAL DIRECTOR'S SIGNATURE	MIT. CECUR	1 250 051	CO BY REGISTRAR 254/MEN	SINTERAN'S SIGNATURE
VR A15 (4) 15M 7-62	7	Wildel U. Kanna The	219 700 lill H	A Hanney APR	4 1967	and Land
14.11	1	A STATE OF THE	LEI L'HOUNE MI	##		

			MARYLAND STATE DEF		
		Division of STATISTIC	AL RESEARCH AND RECORDS, 301	W. PRESTON STREET, BALTIMORE, MARY	LAND 21201
and the second	L	04991 Teem # /	CERTIFICATE	OF DEATH	04991
24 haurs after deoth ad in by the funeral ppers. Pages Yand 72 haurs affer death		PLACE OF DEATH O. COUNTY CARROLL	COUNTY MARYLAND	2 USUAL RESIDENCE (Where deceosed lived, if institution STATE A V A V A	ton Residence before odmission) NIX ARROLL CO.
ours after by the f Poges after afte	1 .	b (ITY DR TOWN (If outside corporate limits, write RURAL and give nearest tawn)	LENGTH OF STAY IN 16	C CITY OR TOWN (If outside corporate limits, write RU MANCHES TER	RAL and give nearest town)
nin 24 ha filled in k popers. thin 72 ha	C.	NAME OF HOSPITAL OR INSTITUT ON (IF not in	miama 1. 1/15000	d STREET ADDRESS RT -H	e is residence on a farm? Yes No
within within stely fil stoom parbon		NAME DF DECEASED (Type or print) AND PRINTS FIRST PARCE FIRST FIRST PARCE FIRST FIRST	EUGENE JE	NNING-S 4. DATE Mon	th Doy Year
ceriticate be executed within physician and completely fills then please remove carbon po movol, and in ony event, withir	5	SEX 6 COLDR DR RACE 7	MARRIED X NEVER MARRIED 8 WIDOWED DIVORCED 8	DATE OF BIRTH FB, 21, 1925 9 AGE (In years lost birthday) 42 yrs	Months Doys Hours Min
icate be ex yskcian and pleose rem bl, and in on	dut.	USUAL OCCUPATION (Give kind of work done no most of working life, even if retired)	10b KIND OF BUSINESS OR HID ISTRY	11 BIRTHPLACE (County & State, or foreign country) SCOTT COUNTY VINCHWIA	12 CIT ZEN OF WHAT COUNTRY?
un ceritica ding physic t. Then ple removol, c	13.	FATHER'S NAME	ENNINGS	11111112 - 14	16-47
attending permit. T	15 (Y	WAS DECEASED EVER IN U.S. ARMED FORCES? is, no, or unknown) (If yes give wor or dates of set		THIR CATE CITY VA.	WNING-S. RT# 2
equires that the physician. signed by the burial-transit burial, cremat		18 CAUSE OF DEATH (Enter only one couse p PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if only, which gove isse to immediate couse (o), stoting the underlying couse	Per line for (o), (b), ond (c).) Partailes Perfected gastrie	uleen	INTERVAL BETWEEN ONSES AND DEATH 36 A
The law re a catending e has been use as the oth prior to	NO	lost. (c)	RIBUTING TO DEATH BUT NOT RELATED TO TH	HE TERMINAL DISEASE CONDITION GIVEN IN PART 1(σ)	19. WAS AUTOPSY PERFORMED?
PHYSICIAN: The law e hospital or attending his certificate has beer stacked for use os the Dept. of Health prior to	CERTIFICATION	200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (I	Enter noture of injury in Port I or Port II of Item 18)	YES AND
IG PHYSICIAI the hospital r this certifice detached for	MEDICAL	20c TIME OF INJURY Month, Day, Yeor Hour o.m. 19		E OF INJURY (Home, form, 20f (City or town) ry, street, office bldg , etc.)	(County) (Stote)
OR ATTENDING be retained by th DIRECTOR: After t ge 3 should be de			all attended the deceased frama	death accurred at 9 M. from causes	and on the date stated above.
OR ATTENI be retained DIRECTOR: A je 3 should led with the		220. SIGNATURE Robert F.	self mo. MO		226. DATE SIGNED 2/1/7/767
O HOSPITAL OR ATTENI Poge 4 may be retained O FUNERAL DIRECTOR: A director, page 3 should should be filed with the		22c. PHYSICIAN'S RUBERTA	F. BELL MD	187 E MAIN WES	THINSTER, MD.
TO HOSPITAL Poge 4 may TO FUNERAL I director, pog should be fil	230	EBURIAL, DREMATION, 236 DATE THERECO		ETERY NICHELSKI	LLE SCOTT VA.
VR A15 (4)	3	FUNERAL DIRECTOR STATES	STMINST ADDRESS, MZ	2So. REC'D BY REGISTRAR 2Sb. R	EGISTRAR S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **CERTIFICATE OF DEATH** 04992 Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution-Residence before admission) b. COUNTA MARYLAND CITY OR TOWN (If outside carporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) URAL and give negres town) NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION d. STREET ADDRESS e. 15 RESIDENCI ON A FARM? YES NO IT 3. NAME OF Middle 4. DATE Month Year DECEASED (Type or print) DEATH 19 5. SEX 6. COLOR OR RACE 8 DATE OF BIRTH AGE (In years last burty day) IF UNDER 1 YEAR IF UNDER 24 HR MARRIED T NEVER MARRIED Months Days Hours WIDOWED | USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS, OR INDUSTRY 12. CITIZENJOF WHAT COUNTRY? during most of working life, even if retired) BOREK 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 17. INFORMANT Address 18. CAUSE OF DEATH [Enter only one couse per line far (a), (b), and INTERVAL BETWEEN ONSET AND DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) **DUE TO** Canditions, if any, which gave rise to immediate Cardine Fa **DUE TO** cottse (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? YES NO T 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, form, Doy, Year 20d INJURY OCCURRED 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour o. m. While Not while of work at work p. m. 4/11/67, 19____that I last saw the deceased 21. I certify that I attended the deceased from _____, and that death occurred at 1015 PM, from the causes and an the date stated above. alive an ADDRESS (Street, city or town, state) **ACTUAL** SIGNATURE NAME (Type) 220 BURIAL CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City 237 FUNERAL DIRECTOR'S SIGNATURE 24a, REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE 15M 9/SS



1	MARYLAND STATE DEPARTMENT OF HEALTH
4	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND O493 CERTIFICATE OF DEATH
t TAA	VIOL
hours after death din by the funeral rs. Pages 1 and 2 hours after death	1. PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY b. COUNTY b. COUNTY
fter the ss 1 fter	Carrie MARYLAND Mel Balte.
s a by 1	b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Jour Jour S. Lack	d. NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 6. IS RESIDENCE
illed Spera	DN A FARM?
di Çiri	3. NAME OF First Middle Last 4. DATE Month Day Year
with grbo	DECEASED OF
a le de	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 18. DATE OF BIRTH 9. AGE (In years FUNDER 1 YEAR IN FUNDER 24 HRS.
se be executed within 24 hours after islician and completely filled in by the lease remble cabon papers. Pages I and in any event, within 72 hours after	Female white WIDOWED DIVORCED 3-5-1877 GO yrs. Hours Min.
in a in a	10a. USUAL DCCUPATION (Give kind of work done 10b. KIND DF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT
be sicia and	during most of working life, even if retired) INDUSTRY Batto Country out factory
phys	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
ng ng ling Ther	Clever Cont Susan Wilhelm.
endi it.	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give war or dates of service)
eath erm on, c	no 217-48-0292 Leslie Keny (soul Batternone had.
the dit p	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN DNSET AND DEATH DNSET AND DEATH
it th an. I by rans cren	PART I. DEATH WAS CAUSED BY: 1MMEDIATE CAUSE (a) Cloute my & carthal Failure 241ms.
PHYSICIAN: The law requires that the death certificate be the hospital or attending physician. This certificate has been signed by the attending physician detached for use all the burial-transit permit. Then please is Dept. of Health prior to burial, cremation, or removal, and in	4251 DUE TO COASS Pol. 6: Part Disease 20445.
ph ph pur bur	Conditions, if any, which gave rise to immediate (b)
ding bee The	cause (a), stating the DUE TO Men was a stating the 25 yrs.
aw tten has am am	underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY
The Torial are use	PERFORMED? YES NO [V
tal Tal	20a, ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Pert I or Part II of Item 18.)
PHYSICIAN: the hospital this certifi detached fo e Dept. of H	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Pert I or Part II of Item 18.) CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
HYS he he h this etac Dep	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
ATTENDING PI retained by th CTOR: After t i should be de vith the State	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hour a.m. p.m. 19 at work at work
0 2 ~ 0 "	21. I certify that (1) this hospital) attended the deceased from 19 to 4-26-67, 1967, that (6) (we) last
ATTENDING I retained by ECTOR: After 3 should be with the State	saw the deceased alive on 4-26 1967, and that death occurred at 3 mm, from the causes and on the date stated above.
OR A.	22a. SIGNATURE 22b. DATE SIGNED ATTENDING MED. STAFF 22b. DATE SIGNED
AL OR DAY be page filed	M.D. PHYS. DIRECTOR PHYS.
SPITAL 4 may ERAL 1 cor, pag	22c. PHYSICIAN'S NAME (Type) M. C. Porterfield Hampstead, Md.
TO HOSPITAL OR ATTENI Page 4 may be retaine TO FUNERAL DIRECTOR: director, page 3 should should be filed with the	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Rurial Lu/29/67 Forest Baptist Cemetery Upperco, Md.
Chr.	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE
VR A15 (4)	Tipton - Eline Funeral Home Hampstead, Md.
15M 4-64 &	



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 1. PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution. Residence before odmission) o. COUNTY o STATE Page 0 Carrell MARYLAND Maryland Baltimore City
OR TOWN (It outside corporate limits, write Rural and give necrest town) b (ITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 write RURAL and give nearest town) hours ofter Departi Sykesville Baltimore I dav d NAME OF HOSP,TAL OR INSTITUT ON (If not in hospital, give street address) d STREET ADDRESS e IS RES DENCE ON A FARM? ce olong with form Pages ate Springfield State Hospital NO THE 911 N. Carrollton YES hours ofter death 3 NAME OF Midd e 4. DATE Lost Dov Year DECEASED G've With h JAMES **EDWARD** KING April 67 (Type or print) 19 DEATH S SEX B DATE OF BIRTH 6 COLOR OR RACE AGE (In years IF UNDER I YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED 10st birthdoy) Months Doys Hours 10-9-16 Male Negro WIDOWED DIVORCED event puo IDO USUA, OCCUPATION (Give kind of work done 11 BIRTHPLACE (State or foreign country) .Ob KIND OF BUSINESS OR 12 CJ ZEN OF WHAT during most of working life, even it refired) INDUSTRY COUNTRY? Ony Rug Cleaner 9 South Carolina II.S.A 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME ≘ ond Unknown (Maiden name unknown IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT removal, (Yes, no, or unknown) (If yes give wor or dates of service Records, Springfield State Hospital 2118-211-8221 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY ONSET AND DEATH 0 Acute fatty change of the liver. IMMED ATE CAUSE (o) Word certificate should cremotion, DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse last. burial, o PART I OTHER SIGNIFICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) 19 WAS AUTOPSY PERFORMED? YES 🚾 NO 200 EXTERNAL (AUSE WAS 206 DESCRIBE HOW INJURY OCCURRED (Enter nature of in any in Port 1 or Port 1 of Item 18) ogent, prior 3 should PRIMARY OF CONTRIBUTING CAUSE OF DEATH 2Dc TIME OF INJURY Month Day, Year 2Dd INJURY OCCURRED 2De PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stote) Hour a.m. factory, street, office bldg . etc } may be retoined for your FUNERAL DIRECTOR: Page at work ot work 21. I certify that I took charge of the rentums described above, held an Autapsy XI Inspection Inquiry | and in my apinian death resulted from Matural causes Suicide Homicide Undetermined manner the funeral director CHIEF MEDICAL EXAMINER **ACTUAL** ASSISTANT MEDICAL EXAMINER SIGNATURE FORENTE Health or it FO DEPUTY DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address Astreet, xit Mosko (pe cought) NAME (Type) 23b DATE THERPOF BURIAL, CREMATION, 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (C tv or Town) (County) REMOVAL (Specify) County Md Calvary Cemetry 24 FUNERAL DIRECT ADDRESS REC D BY REGISTRAR VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04995 CERTIFICATE OF DEATH 04995 ond 2 death. requires that the death certificate be executed within 24 haurs after death 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission). PLACE OF DEATH p. COUNTY o. STATE b. COUNTY C CITY OR YOWN (If outside carparote limits, write RURAL and give neorest town) b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) MARY: AND c. LENGTH OF STAY IN 16 Rural - Sykesville 1y. 6
d. NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street address) Tv. 64 Cumberland 5 STOFET ADDRESS e IS RESIDENCE ON A FARM? paper the ottending physician and completely filled sit permit. Then please remove carbon pape KNE N. Center St. NO 🔽 YES 🗔 Springfield State Hospital NAME OF Clarfey 4. DATE Year Clomenziest DECEASED DEATH (Type or print) 河道治学的 Lambart 9. AGE (In year IF LINDER 24 HRS SEX 6 COLOR OR RACE DATE OF BIRTH 7. MARRIED **NEVER MARRIED** ast pirthday) Months Hours Davs ony WIDOWED DIVORCED 78 YIS. white famala 10a. USLAL OCCLPATION (G ve kind of work done during most of working life, even if retired)

Hhousevite 105 KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) COUNTRY? INDUSTRY Maryland West Virginia TISA 13 FATHER'S MAME Benjamin Shuttlesworth Missouri * Ashby INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, ar unknown) [[If yes give wor or dates of service Springfield Hospital records. Sykeswille. None INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (a) (b) ond (c))
PART I. DEATH WAS CAUSED BY. signed by the buriol-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove rise to immediate cause (a), DUE TO stoting the underlying cause O FUNERAL DIRECTOR: After this certificate has been the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO X associated with senile brain disease with psychotic reaction for 200. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) ro Hospital or Attenbing Physician Poge 4 may be retained by the hospital (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year foctory, street, office bldg, etc.) Not While of work at work , 19<u>66</u> , ta_ 11/28 , 19 67 that \$1) (we) last 21. I certify that (PE(this hospital) ottended the deceosed from 4/22 1/28 19 67, and that death occurred at 10 PM, from causes and an the date stated above. sow the deceased-alive an. 22a SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR **PHYS** 22d. ADDRESS Springfield State Hespital 22c. PHYSICIAN S NAME (Type) Naci Buvukunsal. M.D Sykesville Maryland director, 230 BURIAL, CREMATION, REMOVAL (Specify) 23d. LOCATION (City or Town) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) (State) Alleg Md May 2. Near Cumberland Hillcrest Burial Park 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 1 20 M 1/66

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1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	04996 MEDICAL EXAMINER'S CERTIFICATE OF DEATH DADDE
HEALTH BEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
LAVE	8. COUNTY CARROLL CO MARYLAND ARRYLAND D. COUNTY CARROLL
is necessary, o the funeral ce 5 may be to Department after death.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1D c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
the function of the function o	WESTMINSTER RA. ! UNION BRIDGE RDAL
o the Der	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
ay 3 t 3 t 3 t 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2	DEEP RUN ROAD OFF ROUTE 140
2 gw ~ 90	3. NAME OF PITST Middle Last 4. DATE Month Day Year OF OF DECEASED CORP or print) POBLIC ZZ 1067
	5. SEX 1.6. COLOR OR BACE 17. MARRIED TO NEUER MARRIED TO 4.8. DATE OF BIRTH 19. AGE (in years FUNDER 1 YEAR) FUNDER 24 HRS.
form H awithin	1 Indian I I
ind the	10a, USUAL OCCUPATION (Give kind of work done) 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT
fter c Give g wi 1 al	during most of working life, even if retired) INDUSTRY EMPLOYEE IN GREENHOUSE (FLORIST) MARYLAND U.S.A.
ours affe n 18. G e along pages 1 In any	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
4 hour ltem office of and li	CLAYTON J. LEESE HELEN WEIDNER
24 in 14 offi offi if, an	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or inhorm) (If yes give war or dates of service) 214-36-9641 DANIEL W. LET. C.
I within ! mencil ir miner's permit.	MO TO THE TOTAL TO THE PARTY OF
EXAMINER: This certificate should be executed within 24 hours after certificate, writing the word "pending" in mencil in Item 18. Gind hould be forwarded to the Chief Medical Examiner's Office along libs. DR: Page 3 should be used as a bunial-transit permit. File pages 1 signated agent, prior to burial, cremation, or removal, and in any signated agent.	PART I. DEATH WAS CAUSED BY:
'pending'' in 'pending'' in 'Medical Exar burial-transit	976X PUE TO
id be execu "pending" f Medical bulial-trar cremation,	Conditions, if any, which } (b)
d be 'pe Me Me bulli	gave rise to immediate (cause (a), stating the DUE TO
houf ord thief is a	underlying cause last. (c)
ficate shou the word of the Chie used as a to burial,	PERFORMED?
to the state of th	YES NO YES 208. EXTERNAL CAUSE WAS 206. DESCRIBE HOW INJURY DOCUMED (Enternative for paying for injury in Part 1 of Item 18.)
certif riting ded to ald be prior	20a. EXTERNAL CAUSE WAS PRIMARY DE OF CONTRIBUTING 20b. DESCRIBE HOW INJURY DECORRED TENTER OF INJURY IN PART TO FART TO FILE OF THE PRIMARY DECORRED TO THE PRIMARY DECORRE
R. This cate, write forward forward 3 should agent, p	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20g. PLACE OF INJURY/Home, Yarm, 20f. Conty) (State)
age 1	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY Home, Tarm, 20f. Clary pell (State) Hour a.m. p.m. 4 1967 at work at work at work 1967 at work
the certification in the certi	21. I certify that I took charge of the remains described above, held an Autopsy , inspection , inquiry , and in my opinion
the certifies.	death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner
	ACTUAL ACTUAL ASSISTANT MEDICAL EXAMINER 22. DATE SIGNED
亜 ま 黎 、	ACTUAL SIGNATURE OF THE SIGNED DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY DEPUT
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O DEPUTY M please exec director. Pretained for of Health of	23a, BURIAL, CREMATION, 23b, DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
	13 USIAL (Specify) 4/25/67 ST DAVIOS CEMETERY NR HANDVER PLADAMS COP
	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR'S SIGNATURE
VR A15ME 3500 4-64	JE Myers of Westminder and DATPR 26 1967 Johnson Judge





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH hours after death. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. COUNTY b. COUNTX arroll Carroll Maryland within 72 hours after MARYLAND CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporete limits, write RURAL end give nearest town) Westminster 504RS. filled in I Westminster d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? E. Green Street 143 E. Green St. YES F NO X attending physician and completely rmit. Then please remove carbon pn. or removal, and in any ment, within executed within 3. DATE OF DEATH NAME OF Year First Middle DECEASED (Type or print) MATE ESTELLE April 10 1967 MANAHAN 5. SEX 6. COLOR OR RACE AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. DATE OF BIRTH 7. MARRIED NEVER MARRIED K 8. 9. 70 Months Days female white 1888 27. WIDOWED DIVORCED (Nov. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b, KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT death certificate be COUNTRY? County Health Dent Carroll County U.S.A. nurse 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Charles F. Manaham Ada Nicodemus 15. WAS DECEASED EVER IN U.S. ARMED FORCES? been signed by the attent the burial-transit permit, or to burial, cremation, or r 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unkown) | (If yes give war or dates of service) 219-36-1867 same Miss Martha E. Manahan 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PHYSICIAN: The law requires that the hospital or attending physician. RCINOMA OF COLON WITH METASTASE MONTHS DUE TO Conditions, if any, which (b) gave rise to immediate this certificate has been detached for use as the e Deot, of Health prior to DUE TO cause (a), stating the underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? YES T NO [20a. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) detached for the Dept. of A OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) be detached State Dept. MEDICAL TIME OF INJURY Month, Day, Year (State) 20d. INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm.) 20f. (City or town) (County) factory, street, office bldg., etc.) RECTOR: After to 3 should be de liwith the State Hour e.m. While Not While OR ATTENDING I at work at work 1966 to A/RILIO 1967 that (1) (we) last 21. I certify that (I) (this hospital) attended the deceased from director, page 3 should should be filed with the and that death occurred at 2.31 fM. from the causes and on the date stated above. saw the deceased alive on 1967 22a. SIGNATURE 22b. DATE SIGNED ATTENDING Weam M.D. DIRECTOR PHYS. 4 may HOSPITAL PHYSICIAN'S 22d. ADDRESS NAME (Type) TO h. Page a 23d. LOCATION (City, town or county) (State) 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery Westminster Maryland REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS VR A15 (4) 15M 4-64



\1		EPARTMENT OF HEALTH DI W. PRESTON STREET, BALTIMORE MARYLAND 21201	
2 37	04993 Items #4 & 21 Film #CERTIFICAT	OF W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
funeral	PLACE OF DEATH o. COUNTY CarrollCounty MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence be a. STATE Maryland b. COUNTY Wash	efore odmission)
by the Pages ours after	b CITY OR TOWN (if putside corporate limits, write RURAL and give nearest town) Bakesville, Md. 10 mos.	c. CITY OR TOWN (If outside carporate simits, write RURAL and give nea Hagerstown, Maryland	210
n 24 ho elled in papers.	d. NAME OF HOSPITA. OR INSTRUTION (if not in hospita, give street address) Springfield State Hospital	d STREET ADDRESS 1 E. Baltimore St.	e IS RES DENCE ON A FARM? YES NO 2
law requires that the death certificate be executed within 24 haurs after death nding physician. been signed by the attending physician and campletely filled in by the funeral s the burial-transit permit. Then please remove carbon papers. Pages 7 and is to burial, cremation, or removal, and in any event, within 72 hours after death iar to burial,	3 NAME OF First Mixidle DECEASED (Type or print) Eva Mae Jones May	I DEATH -	Pgy, Year 19 19 67
execute nd comp emove ony eve	S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED 100 USUA, OCC. PATION (Give kind of work done 10b. Kind of Business or	12-31-85 27 79 25 yrs Months Day	rs Hours Min.
cate be sician a siease r and in	during most of working life even if retired) COOK 13. FATHER'S NAME	Maryland COUNTR	U.S.A.
g phys hen p noval	Layman Jones	Rachel Smith	
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hat the n. yy the g ansit pa	18. CAUSE OF DEATH (Enter only one couse per line for (o) (b), and (c) PART 1. DEATH WAS CAUSED BY Congestive Hea		INTERVAL BETWEEN ONSET AND DEATH
equires that th physician. signed by the burial-transit burial, crematy	rice to immediate cause (a)	ic cardiovascular disease	years
ne faw ree ffending p as been s as the b priar ta b	stating the underlying couse (c) Stating the underlying couse (c) Terminal pneum		weeks
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rsician aspital certifical ned far t. of He	S AK COMIKIBOTING TO CHOSE OF DENIA	(Enter noture of injury in the chief it is mile action	
Page 4 may be retained by the haspital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-traishauld be filed with the State Dept. of Health prior to burial, cre	Hour a.m. 19 White Not While of at work of at work of the state of th	ACE OF INJURY (Home, form, ctory, street, office bklg., etc.) 20f (City or town) (County)	
TENDII Jined by OR: Afth Could be	21. I certify that (1) (this haspital) attended the deceased fram—saw the deceased alive on 4-19-19.67, and the	ot death accurred of 3:50M, fram couses and on the d	
OR All be reto DIRECT ge 3 she led with	220. SIGNATURE DE EUM, MD N	A.D. PHYS. DIRECTOR PHYS. D	19-67
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O HOSPITAL Page 4 may O FUNERAL director, pag shauld be fil	230 BURIAL CREMATION, REMOVAL (Specify) BURIAL 4/24/67 ROSE HILL CE	4	
VR A15 (4) B	24 EUNERAL DIRECTOR ADDRESS AGENCY Tuneral Honey 305 N Poion	2Sa REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNA	TURE
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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05000 death. 24 haurs after death attending physician and completely filled in by the funeral permit. Then please remove carban papers. Pages I and an, or removal, and in any event, within 72 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) n. STATE b. COUNTY o. Carroll MARYLAND Baltimore City c LENGTH OF STAY IN 16 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If putside corporate limits, write RURAL and give nearest town) vrs.10mos.21dts. Baltimore Sykesville 8 IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS 3435 Roland Ave. Springfield State Hospital YES NO IX requires that the death certificate be executed within Middle 4. DATE 3. NAME OF First Lost Month Doy Year DECFASED OF 1967 SARAH EDITH MAYS MARCH 12 DEATH (Type or print) 1 YEAR IF UNDER 24 HRS AGE (in years lost birthday) IF UNDER SEX B. DATE OF BIRTH A COLOR OR RACE 7. MARRIED NEVER MARRIED Months Dovs Hours 11-10-1882 Female White WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life even if retired) Factory Worker COUNTRY? INDUSTRY Maryland U.S.A. 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Bennett Hoshall Elizabeth Gore 17. INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO signed by the attendir burial-transit permit. (Yes_no, or unknown) (If yes give wor or dates of service) 218-09-9789 Records, Springfield State Hospital No INTERVAL BETWEEN THE CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART ... DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) Myocardial infarction BUE TO burial, (b) Coronary arteriosclerosis Years Conditions, if any, which gove rise to immediate couse (a). DUE TO stoting the underlying couse as the prior tal TO FUNERAL DIRECTOR: After this certificate has been (Arteriosclerotic cardiovascular disease Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PSYCHOTIC DEPTHS IVE FORCE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? NO X YES [Page 4 may be retained by the haspital or ja 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) Dept. (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) Not While of work of work shauld be 2). I certify that (1) (this haspital) attended the deceased from 5-21-59 to 11-12-67 ___, 19____, that (I) (we) last and that death accurred at 1:50 MAHom causes and an the date stated above. saw the deceased alive an 4-12-67 19 22b. DATE SIGNED 220. SIGNATHRE ATTENDING MED. DIRECTOR STAFF PHYS. \mathbf{x} Ц-12-67 3 M.D. PHYS. director, page 3 should be filed v 22d. ADDRESSSpringfield State Hospital 22c. PHYSICIAN S Agustin del Campo, M. D. NAME (Type) Sykesville, Maryland 23d LOCATION (City or Town) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) 230. BURIAL, CREMATION, REMOVAL (Spenis)
B urlal Middletown. 4/15/67 Middletown Baptist Cem 25b REGISTRAR S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR Wharles Judge VR A15 (4) 1 1967 Tipton- Eline Funeral Home Humpstead. Md. 20 M 1/66V



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 05001 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Carroll Maryland MARYLAND requires that the death certificate be executed within 24 haurs after b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sykesville attending physician and campletely filled in by thet permit. Then please remove carban papers. Pages c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) r LENGTH OF STAY IN 16 papers. Pag hin 72 haurs c 1 mo. 13 das. Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in haspita), give street address) e. IS RESIDENCE ON A FARM? d. STREET ADDRESS Apt. 131 Springfield State Hospital 3905 Edgewood Rd YES NO THE 3 NAME OF Middle First Lost 4 DATE Year DECEASED (Type or print) **MEYERS** Harry **NMN** April DEATH 6 COLOR OR RACE B. DATE OF BIRTH AGE (n years IF UNDER 1 YEAR IF LINDER 24 HRS 7 MARRIED NEVER MARRIED last birthday) Months Dovs Hours WIDOWED DIVORCED 3-4-04 male white and in an 11, BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT COUNTRY? Oa JSUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR Bondsman Maryland

14. MOHER'S MA DEN NAME

Sara U.S.A 13. FATHER'S NAME Maver Mevers - dec. dec IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) 219-32-2028 Springfield State Hospital Remords INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) burial-transit p PART I. DEATH WAS CAUSED BY. ONSET AND DEATH Arteriosclerotic cardio-vascular disease. vears IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave Generalized arteriosclerosis. vears rise to immediate couse (a). DUE TO stating the underlying cause the hospital ar attending O FUNERAL DIRECTOR: After this certificate has been as the 19. WAS AUTOPS)
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Diabetes Mellites. CBS, circulatory disorder, with psychotic reaction. VES C NO 5d μg 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Nat While of work 21. I certify that (1) (this hospital) attended the deceosed from 3-3-67 _____, to___<u>4-16-67</u>, 19____, that (1) (we) last . . 19_ Page 4 may be retained sow the deceased alive an 4-16-67 19 ond that death accurred of 11 a M, from causes and an the date stated above. 22b. DATE SIGNED 22a SIGNATURE ATTENDING MED. DIRECTOR 4-16-67 M.D. PHYS. PHYS. Springfield State Hospital Sykesville, Maryland 2178 22d. ADDRESS 22c PHYSICIAN S Octavio Ruiz, M.D. NAME (Type) 23a. BURIAL, CREMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23h. DATE THEREOF (Stote) (County) New Har Sinai 250 REC'D BY REGISTRAR 256 REGISTRAR S SIGNATURE VR A15 (4) 20 M 1/66 Miarles Juga DATEAPR 2 1 winten

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05002 CERTIFICATE OF DEATH filled in by the funeral / in popers Pages 1 and 2 orthin 72 hours after death. 24 hours ofter death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) o COUNTY o STATE b. COUNTY Carroll MARYLAND Maryland b CTY OR TOWN (If outside corporate limits, write RURAL and give neurest town) C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville Baltimore City IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS YES 🕶 NO Springfield State Hespital 918 E. Chase St. requires that the death certificate be executed within carbon 3. NAME OF Middle DATE Lost Month Dov Year physicion ond completely event wil DECEASED
[Type or print] Belle DEATH Apri 1 Anna Montgemery SFX IF I INDER 24 HRS 6. COLOR OR RACE B DATE OF BIRTH AGE (In years 7 MARRIED NEVER MARRIED remove last birthday) Months Doys Hours DIVORCED WIDOWED Sept. 13 Female. white 10a ...SUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT pleose during most of working life, even if retired) COUNTRY? INDUSTRY USA Mother's helper 14. MOTHER'S MAIDEN NAME ottending phys permit. Then p Herov Montgomery unknown 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. permit. (Yes, no, or unknown) (If yes give wor or dotes of service) Springfield Hospital records, Sykesyille, Me 220-54-6601 no cremation, INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) by the buriol-transit PART I. DEATH WAS CAUSED BY ONSEL AND DEATH IMMEDIATE CAUSE (6) DUE TO signed t buriol, o Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse prior to t hos been the 00 PART 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D. SEASE CONDITION GIVEN IN PART I(o) CBS associated with disturbance of metabolism, growth or nutrition WAS AUTOPSY PERFORMED? for use Heolth NO X O FUNERAL DIRECTOR: After this certificate with senile brain disease, with psychotic reaction 200 ACC DENT WAS UNDERLYING 205. DESCRISE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached for the Dept of P (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (Stote) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) 20c. TIME OF INJURY Month, Doy, Year factory, street, office blda. etc.) Not While of work ģ 2]. I certify that (4) (this haspital) attended the deceased from Sept. 23., 19 53, to Apr. 29., 19 67 that I) (we) last should be retoined Apr. 29 19 67, and that death accurred at 9 4 M, from causes and an the date stated above saw the deceased alive an 22b. DATE SIGNED 220. SYGNATURE ATTENDING DIRECTOR PHYS director, page should be filed 22d. ADDRESS 22c. PHYSICIAN'S Poge 4 may t Springfield State Hespital NAME (Type) Buyukunsal, M.D. 23c NAME OF CEMETERY OR CREMATORY f Med. 709 N. Wolfest. (Stote) 230 BUR AL, CREMATION, 23b DATE THEREOF REMOVAL (Specify) 5/3/67 Johns Hopkins School df **ADDRESS** 2Sp REC'D 8Y REGISTRAR 25b_REGISTRAR S_SIGNATURE 24 FUNERAL DIRECTOR Morlas VR A15 (4) 20 M 1/66



VR A15 (4) 20M 1/65 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05003
CERTIFICATE OF DEATH

_			OLK III IOA I	- OI DEAII			
1.	PLACE OF DEATH a. CDUNTY			2. USUAL RESIDEN			sidence before admission)
	Cerroll		MARYLAND	a, STATE	nd Co	L'TC 1	V'
_	b. CITY DR TOWN (if outside of	corporate limits,	C. LENGTH DF STAY IN 1b		f outside corporate lin		and give nearest town)
	write RURAL and give near	est town)	6 Years		-Syk svill		
	d. NAME OF HOSPITAL OR INS	TITUTION (if not in bo		d. STREET ADDRESS			e. IS RESIDENCE
	. 50	.~~ (30			^ 1	000	DN A FARM?
	1.6). ''	77 36		R. D.	S DOM	. 3	YES NO
3.	NAME OF DECEASED	First	Middle	Last	4. DATE OF	Month	Day Year
		furiel	C.	Morrison	DEATH	m of / and some and a	9, 19 <u>67</u>
	SEX 6. COLOR OR	1. mantital	NEVER MARRIED []	B. DATE OF BIRTH	l last bir		Davs Hours Min.
	'enal Wite			arch 5,19	713 1 74	yrs.	
10: dur	I. USUAL BCCUPATION (Give kind ing most of working life, even I	of work done 10b, KI	ND OF BUSINESS OR DUSTRY	11. BIRTHPLACE (County & State, or foreign	country) 12. CI	TIZEN OF WHAT
I	nn owner & or	perator		Baltimor	e Co., Md		S.A.
13.	FATHER'S NAME			14. MOTHER'S MAI	DEN NAME		
	Frank C. Cro	ooks		Mary	V. Dorse	У	
15	. WAS DECEASED EVER IN U.S. AR	MED FORCES? 16. 5	OCIAL SECURITYNO. 17.	INFORMANT		Address	
(11	is, no, of mucount.	216	5-05-8849 Mr	. Guy W.	Morrison	Same As	#2
_	18. CAUSE OF DEATH [Enter	only one cause per lin	ne for (a), (b), and (c),]				INTERVAL BETWEEN
	PART I. DEATH WAS CAU	IOED DV	rcinoma of cer	viv with av	tonded make	atioic	DNSET AND DEATH
	IMMEDIATE /7/X	1,7	ICINOMA OF CEL	ATV AT CIL CY	recinaca meta	S L a S L S	through
	Conditions, if any, which \	DUE TO	st radiation,	intectinal	obstruction		4/19/67
	gave rise to Immediate		be radracton,	111000011101	00001 4441		9/12/0/
	cause (a), stating the underlying cause last.	DUE TO	rdiac failure	and panding	a series a tr		
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IFIC	203 ACCURENT WAS UNDEDLY	VINC III LOOK D	ESCRIBE HOW INJURY OCCU	DRED /Fetor esturo	of Jahury In Gart I or B	art II of Itam 19	YES NO
CERTIFICATION	20a. ACCIDENT WAS UNDERLY OR CONTRIBUTING CAUSE (IF EITHER, NOTIFY MEDICAL	DF DEATH EXAMINER)	ESCRIBE HOW INJUST COCO	ARED. (Ellet haluld t	n mjuty in Fact i Ar Fe	art 11 of 110111 10.	
MEDICAL	20c. TIME OF INJURY Month	a, Day, Year 20d. IN	JURY OCCURRED 20e. PLAC	CE OF INJURY (Home, i	arm, 20f. (City or to	own) (Cou	nty) (State)
9	Hour a.m. p.m.	While 19 at work		J, attect, office bidg.,	614.7		
#4			d the deceased from D	ec.	ig 66 to 4/19	767 19	that (I) (we) last
			19 6.7 and that				
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	Home	2 / X	tall M.D	ATTENDING DE	MED. STAFI	Anr	il 20, 1967
	22c. PHISICIAN'S	Ch C I Y	11.0	1 22d ADDRESS			
	NAME (Type) HOV	ward E. Hal	1, M.D.	Syke	esville, Mar	yland	
23 a		DATE THEREDE	23c. NAME OF CEMETERY	OR CREMATORY	23d. LOCATION (City, town or cou	nty) (State)
	Burial 4/2	22/1067	Lakeview Me	morial G	andone o	arroll	Co 'A
24	FUNERAL DIRECTOR		ADDRESS	25a. RI	C'D BY RECISTRAR 2	5b. REGISTRAR	SIGNATURE
(. M. Waltz Ro	ox 241 Sv	kesville. Md	DATE A	PK 24 1987	ycuan	Can Vincenza
-			110	- V DATE	- 1001		A-0



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05005 CERTIFICATE OF DEATH signed by the attending physician and completely filled in by the funeral burial-transit permit. Then please remave carbon papers. Pages 1 and 2 burial, cremation, or remaval, and in any event with my 2 hours after death. law requires that the death certificate be executed within 24 hours after deathy PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission a. COUNTY a. STATE b. COUNTY Carroll, Maryland Maryland MARYLAND C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate simits, write RURAL and give nearest town) b CITY OR TOWN (If autside carporate mmits, write RURAL and give nearest tawn) 10y. 7m. 26d Baltimore (Rural) Sykesville d. NAME OF HOSPITAL OR INSTITUTION (1) nat in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital 229 E. 32nd. Street YES NO DE 3. NAME OF Middle 4. DATE First Month Day Year DECEASED Charles William O'Neill 10 67 (Type or print) DEATH 19 S SEX IF UNDER 1 YEAR 6. COLOR OR RACE DATE OF BIRTH 9 AGE (n years IF UNDER 7 MARRIED NEVER MARRIED birthday) Days Haurs white 5-23-90 male WIDOWED DIVORCED 10a. JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or Fareign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Bay Pilot s Maryland
14. MOTHER'S MAIDEN NAME on ships USA John R. O'Neill Margaret Lastner IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. Address (Yes, no or unknown) {(If yes give wor or dates of service) 218-32-3886 Hospital Records 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (6) Pulmonary Emphysema VYS DUE TO Chronic Bronchitis Conditions, if ony, which gave years rise to immediate cause (a), DUE TO far use as the t Health priartat stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached far use as the Generalized arteriosclerosis years PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? Chronic brain syndrome associated with psychotic reaction. NO the haspital ar ACCIDENT WAS DIRECTING TO THE 1205 DESCRIBE FROM HOURY OCCURRED. (Enter noture of injury in Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH of (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) factory, street, affice bldg., etc.) Haur a.m. **Hot-While** O HOSPITAL OR ATTENDING Page 4 may be retained by 21. I certify that (1) (this haspital) attended the deceased fram_ 8-14 156 , to 4-10 _, 1967, that (1) (we) last 19 67, and that death accurred at 11:50 fram causes and an the date stated above. saw the deceased alive an_ 220. SIGNATURE ----22b. DATE SIGNED **ATTENDING** 4-10-67 DIRECTOR PHYS. Springfield State Hospital 22d. ADDRESS NAME(Type) Mario E. Comas. M.D. Sykesville, Maryland director, should be 23c. NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d. LOCATION (City or Town) 23g, BURIAL CREMATION. (County) (Stote) REMOVAL (Specify) Burial Baltimore, Maryland Holy Redeemer Cemetery Apr. 13,1967 Wm. Cook-Brooks Towson, 1050 York Road 2So REC'D BY REGISTRAR 2Sh. REGISTRAR'S SIGNATURE VIII A15 (4) 20 M 1/66 1967 Towson, Md. 21204



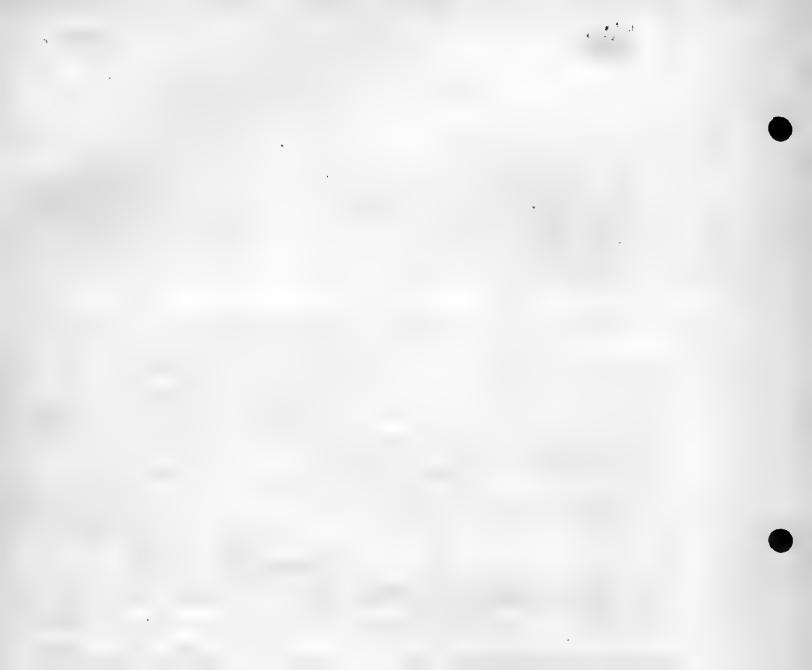
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er's	mit		No		U	nk.	Re	cords, Spri	ngfield	State H		
EXAMINER: This certificate should be executed within 24 hours after death. If a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, hould be forwarded to the Chief Medical Examiner's Office along with form	permit. removal					Ime for (a), (b), and (TERVAL BETWEEN
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18







4 1	MARYLAND STATE DEPARTMENT OF HEALTH Applyision of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
FOR STATE	05070 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
неадун дерт.	1. PLACE OF DEATH a. COUNTY Carroll MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland Carroll
cessary, funeral may be artment r death.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
o the funde 5 may Departual after di	Westminster d. Name of Hospital Or Institution (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
3 to the Page tate Durs aff	ON A FARM?
delay is and 3 to Page. State hours	3. NAME OF First Middle Last 1.4. DATE Month Day Year
ny del 2, and 13.	(Type or print) FARI David PDD D BEATH 4- 9 1967
	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER 1 YEAR IFUNDER 24 HRS. last birthday) Months Days Hours Min.
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or de ive I with	10a. USUAL OCCUPATION (Give kind of workdone during most of working life, even if retired) Farmer 11. BIRTHPLACE (State or foreign country) INDUSTRY Farming 12. CITIZEN OF WHAT COUNTRY? U.S.A.
	13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
hou lice	George W. Roop Berta Nogle
24 0ff 8	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or Linkown) (If yes give war or dates of service)
within pencil in miner's miner's removal.	No 219-36-1146 Mrs. Mary Agnes Roop, R# 1M, Taneytown, Md.
or Example	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ONSET AND DEATH Secondary ONSET AND DEATH ONSET AND DEATH ONSET AND DEATH
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writing writing inded to make to prior prior	E PRIMARY OF CONTRIBUTING CAUSE OF DEATH.
ER: This cer icate, writin e forwarded e 3 slouze i	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hour a.m. While at work at work at work at work
AL EXAMINE The Certification of the certification o	21. I certify that I took charge of the remains described above, held an Autopsy, Inspection X, Inquiry, and in my opinion
EXA Shoul files.	death resulted from: Natural causes X, Accident , Suicide , Homlolde , Undetermined manner
	ACTUAL 11 ACTUAL CALLET MEDICAL EXAMINER 22. DATE SIGNED
or Day	ACTUAL SIGNATURE SIGNATURE DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY DEPUTY MEDICAL EXAMINER DEPUTY DEP
	EXAMINER'S W. Glenn Speicher Address English division in the Carrell
O DEPU please directo retaine O IIII	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 4/12/1967 Keysville Union Cemetery Keysville, Maryland
(H)	24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15ME 35DD 4-64	John M. Skill C.O. Fuss & Son, Taneytown, Md. DATE 11 1967 Julye



YI AND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH USUAL RESIDENCE (Where dacesed lived, If institution, Residence before admission) e. COUNTY **b.** COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town) b. CITY OR TOWN (if outside comprate limits. c. LENGTH OF STAY IN 16 write RURAL and give nearest town) DLEBURG n. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street ON A FARM? YES NO D completely 3. NAME OF Year DECEASED 19 6 / (Type or print) DEATH 5. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS OR RACE 7. MARRIED NEVER MARRIED and last birthday) Months | Days Hours certificate physician 12. CITIZEN OF WHAT COUNTRY? 10a USJAL OCCUPATION (Give kind of work & State, or foreign country) done during most of working life, even if retired) Address EVER IN U.S. ARMED FORCES? (If yes alve war or detes of service) 18. CAUSE OF DEATH [Enter only one cause per line for (e., (b), and (c)) PINSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (6) pava rise to immediate cause DUETO (a), sleting the underlying causa last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED Cardio Canular DESCRIBE HOW INJURY OCCURED, (Enter nature of injury in Pert , or Pert I of item 18.) OR CONTRIBUTING [] CAUSE OF DEATH OF EITHER, NOTHEY MEDICAL EXAMINER, 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, ferm, 20c. TIME OF INJURY Month, Day, Yeer 20f. (City or town) (County) (Slate) fectory, street, office bldg., etc.) While Not While el work at work to..../ saw the deceased alive on 228 DATE 270. SIGNAT ATTENDING death. Page 4 DIRECTOR M.D ADDRESS 22c PH filed NAME OF CEMETERY OR CREMATORY (Stele) LOCATION (City, fown or county) 23a. BURIAL CREMATION 表表 26a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE VR A1S {4} ISM 7:61



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05012 CERTIFICATE OF DEATH 05012 requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH **b.** COUNTY a. COUNTY n STATE MARYLAND Manyland Carroll

c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) Carroll flarroll the attending physician and completed filled in by the fr st permit. Then please remove capon agrees. Pages nation, or remayol, and in any event within 72 hours afte b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) C LENGTH OF STAY"IN 1b > Finksburg .Route#2 6 mo's. 19das. Sykesyille e IS RESIDENCE ON A FARM? d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) Springfield State Hospital YES NO y 4. DATE Middle Day Year 3. NAME OF Last DECEASED 19 67 DEATH April 30 Shauck (Type at print) Wesley Jarrett 9 AGE (In years IF LINDER I YEAR IF UNDER 24 HRS. 8. DATE OF BIRTH 6. COLOR OR RACE W NEVER MARRIED 7. MARRIED last birthday Manths Days Haurs Wh tite WIDOWED DIVORCED ond in ony 7-20-91 Malo 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 10b COUNTRY? during most of working life, even if retired) INDUSTRY Maryland Butcher 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME Eliza Barber William Shauck 17. INFORMANT WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. (Yes, na, ar unknawn) (If yes give war ar dates of service 218-32-2664-A Records, Springfield State Hospital No crematian. INTERVAL BETWEEN BUSHI AND DEATH 18. CAUSE OF DEATH (Enter only one cause per line for (a)? (b), and (c).) signed by the buriol-fronsit puriol, crematic PART I. DEATH WAS CAUSED BY numoned IMMEDIATE CAUSE (a) physician. DUE TO Canditians, if any, which gave rise to immediate cause (a). DUE TO attending p stating the underlying cause hos been os the last. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) NO O FUNERAL DIRECTOR: After this certificate the hospital or ģ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Port II of Item 18.) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (State) 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Manth, Day, Year factory, street, affice blda., etc.) Haur a.m. Nat While at wark 21. 1 certify that (1) (this haspital) attended the deceased fram 10/11/66 to 4/30/67 ... 19____, that (I) (we) last be retoined plnods 1967, and that death occurred an eliste M, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22g, SIGNATUM ATTENDING DIRECTOR PHYS. M D director, page should be filed 22d ADDRESS Springfield State 22c PHYSICIAN'S Sykesville, Maryland 21784 NAME (Type) Connor Jr. should 23d LOCATION (City or Town) (State 23c. NAME OF CEMETERY OR CREMATORY (Caunty) 23b. DATE THEREOF 23a BURIAL CREMATION REMOVAL (Specify) surial 25b. KEGISTRAR'S SIGNATURE 2So REC'D BY REGISTRAR ADDRES 24. FUNERAL DIRECTOR VR A15 (4) 1967 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



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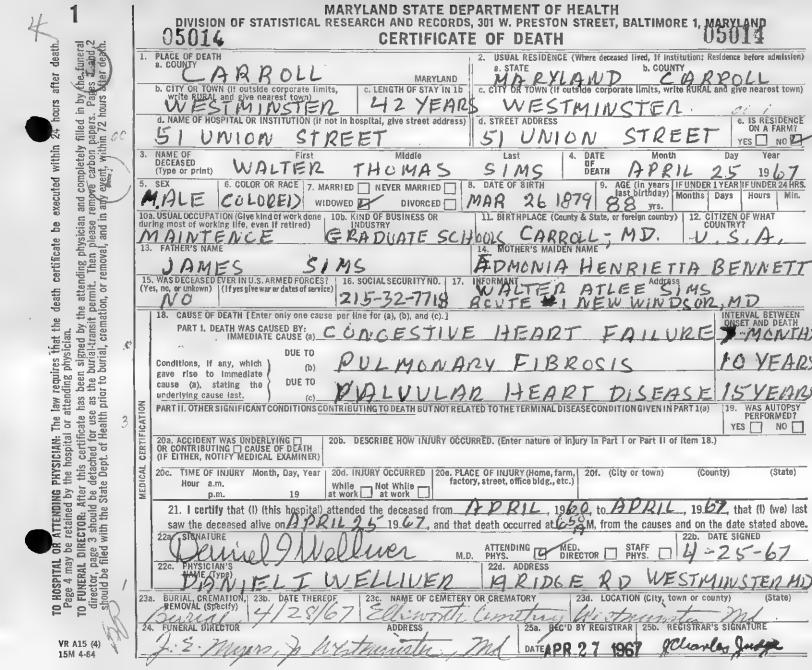
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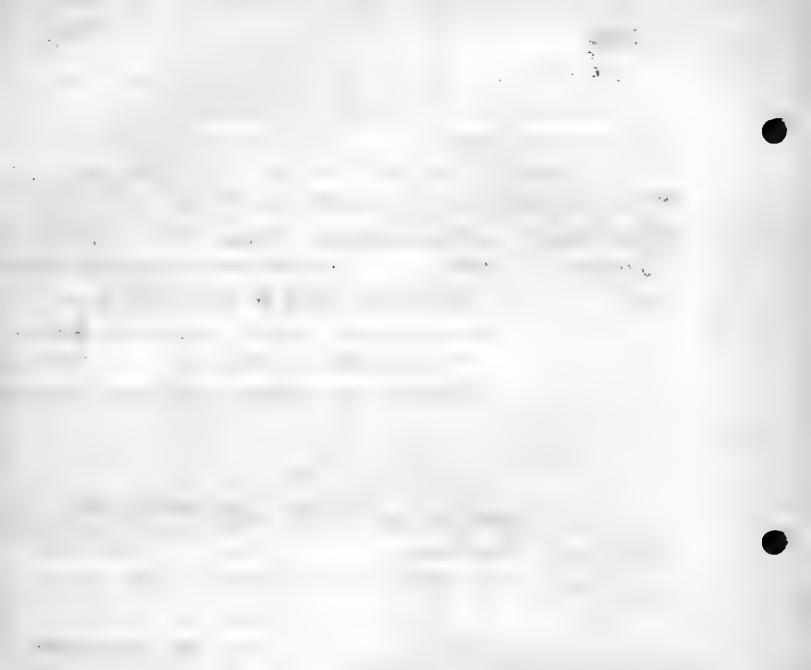
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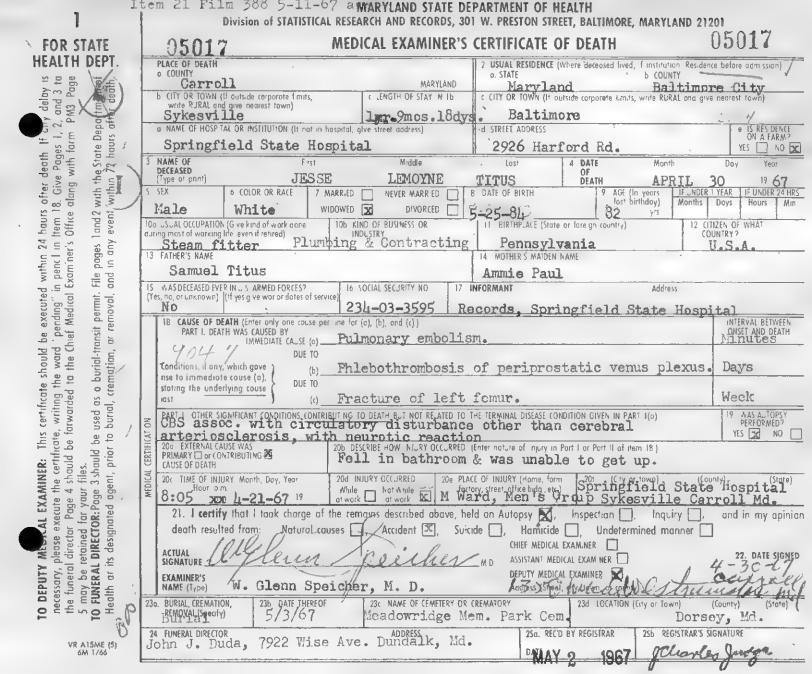
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05015 CERTIFICATE OF DEATH 95015 The low requires that the death certificate be executed within 24 hours after death the ottending physician and completely filled in by the funeral sit permit. Then please remove corbon papers. Pages 1 and nation, or removal, and in any event, within 72 hours attended the PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) o. COUNTY o. STATE **b.** COUNTY Marvl and Carroll MARYLAND b CITY OR TOWN (If outside corporate limits CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
Sykesville 1 vr.5mo.25das. Baltimore d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street oddress) d. STREET ADDRESS B IS RESIDENCE ON A FARM? 3508 Ellamont Rd. Springfield State Hospital YES 🔲 NO 🎏 NAME OF Middle DATE Month Doy Year DECEASED MINNIEM -ST. PAUL 1967 (Type or print) SMITTH April DEATH 6. COLOR OR RACE DATE OF BIRTH 9 AGE (n years IF UNDER I YEAR I IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED last birthday) Doys Hours 12-28-72 WIDOWED DIVORCED Female Negro 10o JSUAL OCCUPAT ON (Give kind of work done 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Private Family domestic New York 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Katie E. Smith Uriah St. Paul 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) Lincoln Bowd 3508 Ellamont Rd. Balt. Md. buriol, cremation, no 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN signed by the buriol-transit ONSET AND DEATH S CALSED BY.
IMMEDIATE CAUSE 10/ADVANCED. Generalized ARteriosylemotic the hospital or attending physicion. Heart Disease **DUE TO** Conditions, if any, which gave rise to immediate couse (o). r this certificate has been si detoched for use as the b te Dept, af Heolth prior to b DUE TO stoting the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(p) 19. WAS AUTOPSY PERFORMED? Chronic brain syndrome assoc. w/cerebral arteriosclerosis w/psychotic vs T 20o. ACCIDENT WAS UNDERLYING [7] 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of Item 18.) TO action. OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20e PLACE OF INJURY (Home, form, 20d. INJURY OCCURRED 20f. (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) of work ot work O FUNERAL DIRECTOR: After director, page 3 should be d should be filed with the Store Page 4 may be retained by 2). I certify that (I) (this haspital) attended the deceased fram 11-1-65 19 4-25-57, 19___, that (1) (we) last . fa._ saw the deceased alive an 11-25-67 19____, and that death accurred at aib PM, fram causes and an the date stated above. 22o. SIGNATURE 22b. DATE SIGNED ATTENDING 1-25-67 anus M.D. PHYS DIRECTOR PHYS. 22c. PHYSICIAN S 22d. ADDRESS NAME (Type) 23o. 8URIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) Buri 21 Poughkeepsie, N.Y. Fourthkeepsie Rural Cens 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) 20 M 1/66 Herbert E. Mutter 3035W. North Ave. Balt. Ad

MARYLAND STATE DEPARTMENT OF HEALTH



17	1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND A
	d a market	05016 CERTIFICATE OF DEATH
	ter death.	1. PLACE OF DEATH a. COUNTY CArrell MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Md. CArrell CArrell
	hours after d in by the rs. Pages 2 hours after	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
	n 24 hours y filled in b papers. Pa thin 72 hours	Jykesville. J. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MANIET ADDRESS O. IS RESIDENCE ON A FARM? YES NO []
	icate be executed within 24 h physicia, and completely filled n please remove carbon papers val, and in any event, within 72	3. NAME OF DECEASED (Type or print) AIMA INER STANTON DAY YEAR OF DEATH APRIL 23 1967
	execute and co remove any ev	Female Col. WIDOWED DIVORCED 6-20-/9/16 Soyrs. Months Days Hours Min.
	ysician please, , and in	10a. USUAL OCCUPATION (Give kind of workdone during most of working life, even if retired) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or fereign country) 11c. CITIZEN OF WHAT COUNTRY? 11c. BIRTHPLACE (County & State, or fereign country) 11c. CITIZEN OF WHAT COUNTRY? 11d. MOTHER'S MAIDEN NAME
	ertif ding The remo	William Muers Etta Thornton
	death of atten permit. ion, or	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
	at the ian. d by th ransit cremat	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PRODUCT PRODU
	ires the physic n signe burial.	Genditions, If any, which gave rise to immediate (b) Cardiac failure, through
	w required to the second secon	cause (a), stating the DUE TO 4/23/67 underlying cause last. (c) Arteriosclerotic heart disease, Hypertension
	The last or at ficate hor use or use Health	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 202. ACCIDENT WAS UNDERLYING 204. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 30 CONTRIBUTING CAUSE OF DEATH 10 CONTRIBUTING 10
	SICIAN hospitals certifications certifications achell fept. of l	
	NG PHY by the fter thi be lets	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 4 4 4 4 4 4 4 4 4
	O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death of Page 4 may be retained by the hospital or attending physician. O FUNERAL DIRECTOR: After this certificate has been signed by the attendirector, page 3 should be letachell for une as the burial-transit permit, should be filed with the State Dept. of Health prior to burial, cremation, or a should be filed with the State Dept.	21. I certify that (I) (this hospital) attended the deceased from April 17, 1967, to April 23, 1967, that (I) (we) last saw the deceased alive on April 23, 1967, and that death occurred at 10 AM, from the causes and on the date stated above.
	AL OR A ay be r L DIREC page 3 filed wi	22a. SIGNATURE (22b. DATE SIGNED ATTENDING MED. STAFF PHYS. April 25, 1967
	HOSPITAL age 4 may FUNERAL rector, pa ould be fil	NAME (Type) Howard E. Hall, M.D. Sykesville, Maryland
	古書	23a, BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) PUT 1 4 27-67 PAISY (hurch Cametery Drawlers) 24. FUNERAL DIRECTOR ADDRESS 1 25a. REG'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
	VR AI5 (4) 20M 1/65	Harry W. Haight Sykesvelle, Mld. DATMAY 1 1967 goliantes Judge







19	MARYLAND STA	ATE DEPARTMENT OF HEALTH	
	05018 CERTII	FICATE OF DEATH	05018
	1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, if inst a. STATE () b. COUNTY	
		reand med Her	
- 1	b. CITY OR TOWN (if outside corporate limits, write RURAL end give nearest town)	1	KAL and give neerest fown)
		sup. Sheet, ma-	1 - 1
n	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street add	d. STREET ADDRESS	e, IS RESIDE
# T	Jongvew Nursing Nove 128NY		YES NO
	3. NAME OF DECEASED Middle	Lest 4. DATE Month	Day Year
	(Type or print) James' Mel	me Journsly DEATH CHOICE	196
	5. SEX 6. COLOR OR RACE 7. MARRIED HEVER MARRIE	ED	UNDER 1 YEAR IF UNDER 24
-] [male white WIDOWED DIVORCE	ED YES.	
71	10b. USUAL OCCUPATION (Give kind of work done shiring most of working life, even if retired)	R INDUSTRY 11. BIRTHOLACE (County & State, or foreign country)	12, CITIZEN OF WHAT COU
	Painter -	Harford Co on Farm	usa.
	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
H	James Townsley	anne toke	
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (1) SOCIAL SECURITY N	NO 17. INFORMANT Address	
	2/8-03 22	68 mis shore Philips doubter	I menchester,
	18. CAUSE OF DEATH (Enter only one cause per tine for (e), (b), and ((c)]	INTERVAL BETWE
	PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Concluded	11 soular accedent	10 days
	DUE TO _ /		
	Conditions, if eny, which \ (b) Centernas	eliente Canda Vascular	v / lyr
	gave rise to immediate cause	2	,
	(a), stating the underlying cause last.	Media	
		TH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN	IN PART I(e) 19. WAS AUT
7	Decl. to mellita		YES NO
	20a, ACCIDENT WAS UNDERLYING . 20b. DESCRIBE HOW INJURY	OCCURED (Enter nature of in ury in Part I or Pert II of Item 18.)	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEA Calles McClett 208. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
		, 20e, PLACE OF INJURY (Home, ferm, ; 20f. (City or town)	(County) (St
	Hour a.m. While Not While	fectory, street, office bldg., etc.)	
		2/30 27 4/11	10/71.00
	21. I certify that (1) (this hospital) attended the decease		
		and that death occurred at 30 M, from the causes and	on the date stated at
	22e. SIGNATURE	ATTENDING MED. STAFF	1/151
	WIT toward	M.D. PHYS. DIRECTOR PHYS. 22d, ADDRESS	- 4//3/6
,	22c PHYSICIAN'S NAME (Type) // II FO 4 -/	D MANGLESTE	11/2/11/1
,	1 100110 100	TOTAL CICLOSTONICS	or county) (State
	REMOVAL (Specify)		7 7
_0	YOURING WAS 18 18 18 EWI	ORY TREET,	MARFORD CEIL
4	2 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	APR 19 1967	Cyles udge
V	John M. Hadema TEL	TA TA DATE " I U IOUT	

* A Property of the second

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e. IS RESIDENCE DN A FARM?

YES NO 57

Year

Hours

INTERVAL BETWEEN ONSET AND DEATH

4/8/67

through

4/22/67

67 that (I) (we) last

YES [

(County)

WAS AUTOPSY PERFORMED?

NO [

(State)

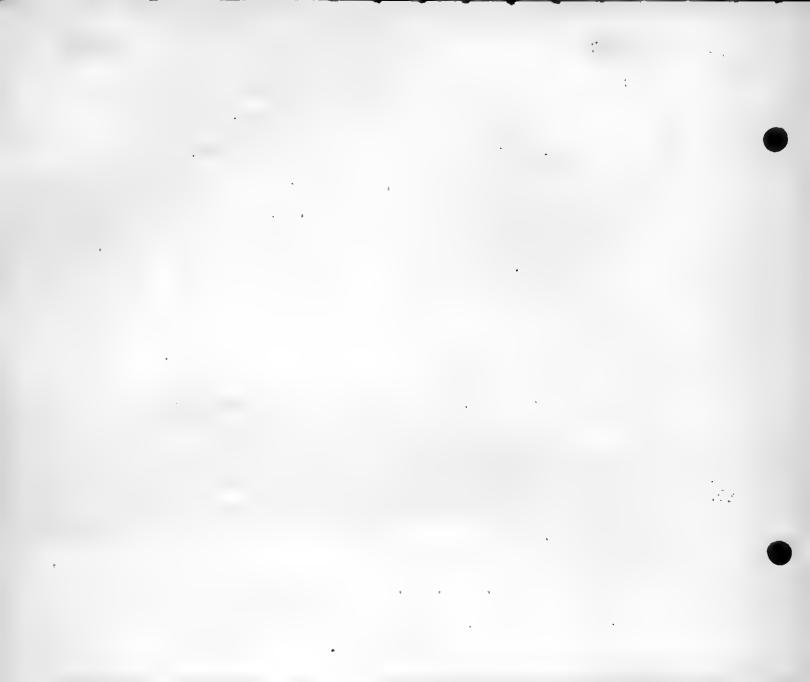
(State)

COUNTRY?

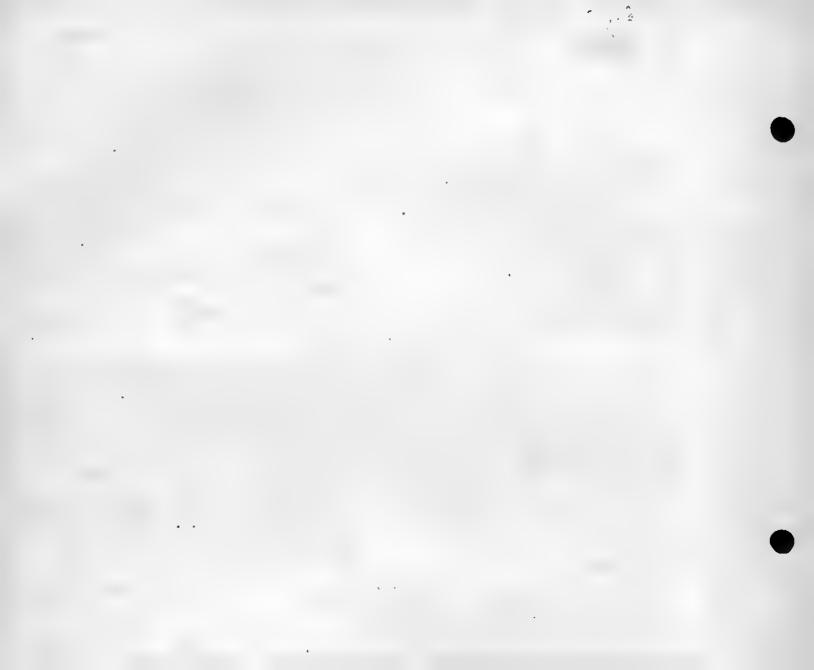
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MARYLAND STATE DEPARTMENT OF HEALTH



Lo	1 /	ارع	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
7		X	05021 Ite CERTIFICATE	A389 5/25/67 NV	5021	
	\$ E 8 8 N	V		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence E	pefare admission)	
	funeral formal		G COUNTY , Carroll MARYLAND	o. STATE Maryland b. COUNTY Carr	077	
	urs ofte Pages urs ofte	ŀ	b. CITY OR TOWN (If outside corporate I mits. C LENGTH OF STAY IN 1b c	c. CITY OR TOWN (If autside carparate limits, write RURAL and give ne		
_	by the Page		write RURAL and give nearest town) Rural Westminster	Rural Westminster	,	
	hol in b irs. 2 ho			d STREET ADDRESS	B IS RESIDENCE ON A FARM?	
	ed within 24 hours offer pletely filled in by the fu corbon papers. Pages 7 ent, within 72 hours offer	1/2	Route # 7	Route # 7	ON A FARM?	
	- 草 电器		3 NAME OF First Middle	Last 4. DATE Month	Day Year	
	ix det		DECEASED (Type or print) Susan Grace W	OF	23. 19 67	
	completely ove corbor			DATE OF BIRTH 9 AGE (In years IF UNDER TYE	EAR IF UNDER 24 HRS.	
	e death certificote be execut attending physician and com permit. Then please remake on, or removal, and in any ev	\mathcal{M}		llv 30. 1904 62 yrs. Manths Do	αγs Hours Min,	
	ond ond		10a JSUAL OCCUPATION (G ve kind of work done 10b KIND OF BUSINESS OR	11. BIRTHPLACE (County & State, or foreign country) 12. CITIZE	EN OF WHAT	
	d an and	4	during mast af warking life, even if retired) INDUSTRY Housewife Own home	Maryland U.S		
	itot Per	ı		14 MOTHER'S MAIDEN NAME	4.84	
	Ph)		Charles Marquet	Flora Lembert		
	ing the man	ı	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFO (Yes, na, arunknown) (Iff yes give wor ar dates of service) 220 / 6 7850	ORMANT Address		
	attendi permit.			Command Watches Af D # C Washing		
	equires that the death certificate be exerphysicion. signed by the attending physician and comburial-transit permit. Then please remoburial, cremation, or removal, and in any	F	18 CAUSE OF DEATH (Enter anly one cause per line (or (a), (b), and (c))	Carroll Weishaark R # 7 Westmi	INTERVAL BETWEEN	
	of the the rsit		PART DEATH WAS CAUSED BY:		ONSET AND DEATH	
	equres that the physician. Signed by the burial-transit burial, cremat		IMMEDIATE CAUSE (a) DUE TO		2	
	ysic ysic ned- ial,		Conditions, if any, which gave) (b)		2 yrs	
	Physical Phy		rise to immediate cause (a).		- j	
	ing sen		stating the underlying cause (c)			
	s bos		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE	TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AJTOPSY PERFORMED?	
	O HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death. Page 4 may be retained by the hospital or attending physician. D FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remark corbon pagers. Pages 1 each should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours offer death.	Si.	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Ent. of Contributing Cause of Death (February Manager))		PERFORMED?	
	AN: or lor for l		200. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURRED. (End	Iter nature of injury in Part I or Part II of Item 18)		
	SICI spitos ertifi ed 1			,		
	ho ho dept		20c. TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 20e. PLACE C	OF INJURY (Home, form, 20f. (City or town) (County	y) (State)	
	DING PH' d by the h After this d be detact		Hour a.m. 19 While Nat While factory, p.m. 19 at work at wark	r, street, affice bldg., etc.)		
	Para Para Para Para Para Para Para Para		21. I certify that (I) (this hospital) attended the deceased from the	Man r l 1 19 157 , to co Mr 244, 1945	7, that (I) (we) last	
_	R. /		sow the deceased olive on Colonial 19/11, and that d	death accurred at 11:30 PM, from causes and on the	dote stated above.	
	Fig Sp St H		220. SIGNATURE	22b. DATE		
	be red w		Mees wilkens MD.	ATTENDING PHYS MED. STAFF PHYS. D 4-5	14-67	
	AL SOUTH		22c. PHYSICIAN'S	22d. ADDRESS		
	TO HOSPITAL OR ATTEN Page 4 moy be retoined O FUNERAL DIRECTOR: director, page 3 should should be filed with the	1	NAME(Type) E. Reese Wilkens	15 Kemper Ave., Westminster,	Md.	
	Je 4	· [230. BURIAL CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CRE	EMATORY 23d. LOCATION (City or Town) (Co	ounty) (State)	
	O Se di Piere		REMOVAL (Specify) Burial April 26,1967 Baust Cemeter	y Tyrone, Carroll Co	Maryland	
	VR A15 (4)	2	24 FUNERAL DIRECTOR ADDRESS ADDRESS	2So REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGN	IATURE ~	
	20 M 1/66	J	C.O. Fuss & Son Taneytown Maryl	and DAAPR 27 1967 Aclienter	Judge	



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 05022 CERTIFICATE OF DEATH low requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH g. COUNTY o. STATE b COUNTY filled in by the fune papers. Pages 1: whin 72 hours offer d Carroll
b (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland MARYLAND Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 15 Baltimore Sykesville L2vrs.23dvs. d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 1924 S. Hanover St. Springfield State Hospital NO TX 3. NAME OF Middle 4. DATE Doy tost Month Year by the attending physician and completely transit permit. Then please remove carbon DECEASED OF DEATH APRIL 67 CAROLINE (NMN) WENGERT 19 Type or print S SEX IF UNDER VEAR IF UNDER 24 HRS. 6 COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7 MARRIED **NEVER MARRIED** birthdoy) Months Doys Hours 11-15-1879 Female White X WIDOWED DIVORCED and in an 10a USUAL OCCUPATION (Give kind of work done KIND OF BUSINESS OR 10h 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working the, even if retired)
Housewife INDUSTRY COUNTRY? Germany link. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol, Heinrich Utz Rosina (last name unk. 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service 220-54-7428+T Records, Springfield State Hospital cremotion, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY Gangrene of left arm IMMEDIATE CAUSE (o) Page 4 moy be retoined by the hospitol or attending physician. DUE TO Marked generalized arteriosclerosis Conditions, if any, which gave Years (b) rise to immediate couse (a). DUE TO stoting the underlying cause of FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the chand he filed with the State Dept. of Health prior to lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) Schizophrenic reaction, paranoid type WAS AUTOPSY PERFORMED? NO X 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) 200 ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e, PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (City or fown) (Stote) (County) Hour o.m. Not While foctory, street, office bldg., etc.) of work 21. I certify that (I) (this haspital) attended the deceased fram. , 19___, that (I) (we) last to 4-14-07, 19__, that (I) (we) last M, fram causes and an the date stated abave. saw the deceased alive an 4-14-67 19 and that death accurred at 220. SIGNATURE 22b. DATE SIGNED **ATTENDING** MED. DIRECTOR 定 4-14-67 PHYS SpringfieldState Hospital 22c. PHYSICIAN'S 22d. ADDRESS Antonius Glahn. NAME (Type) Sykesville, Maryland 23o. BURIAL, CREMATION, 23b. DATE THEREO! 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) (County) REMOVAL (Specify) 250 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE EUNERAL DIRECTOR **ADDRESS** VR A15 (4) 20 M 1/66

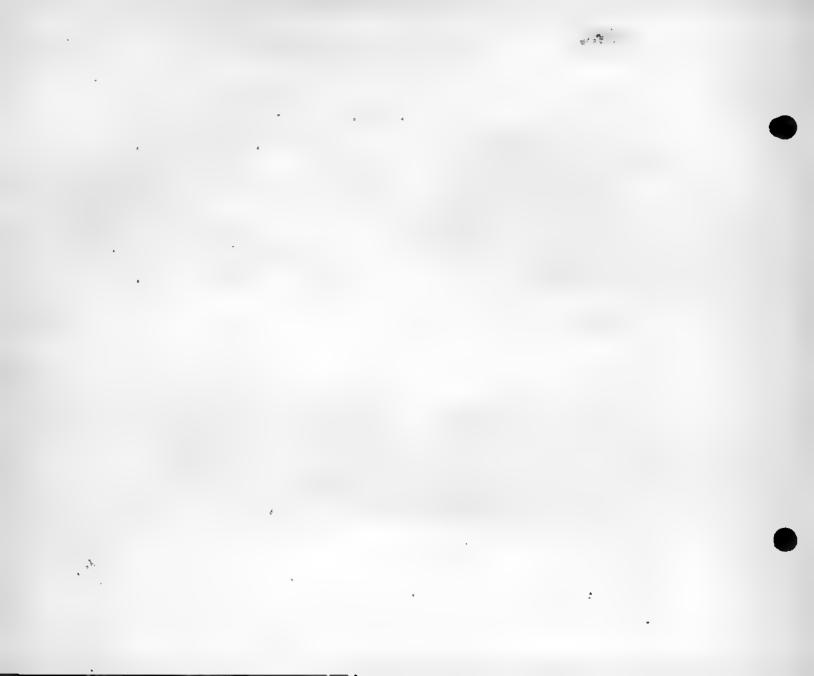
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DIVISION OF STATISTICAL RESEARCH AND RECORDS RESTON STREET, BALTIMORE 1, MARYLAND I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institutions a. COUNTA b. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 16 WNVIII outside corporate limits write RURAL and give nearest town) write RURAL and give nearest town) Arrebola d. NAME OF HOSPITAL OR INSTITUTION (if not in hospita, give street address) . IS RESIDENCE REET ADDRESS ON A FARM? YES NO 4. DATE Month DECEASED (Type or print) DEATH 6. COLOR OR TACE 7. MARRIED NEVER MARRIED IF UNDER 24 HRS. 5. SEX AGE (In years | IF UNDER I YEAR 8. DATE OF BIRTH last birthday) Months Hours DIVORCED 12. CITIZEN OF WHAT COUNTRY? KIND OF BUSINESS OR INDUSTRY 11 done during most of working life, even if retired) 13. FATHER'S NAME SOCIAL SECURITY NO : 17. Address (Yes, no, or unknwn) | [Ifyasgive war or detes of service] 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] ONSET IIII DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **DUE TO** Conditions, if any, which (b)_ gava rise to immediate cause DUE TO (a), stating the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON G VEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20st, ACCIDENT WAS UNDERLYING LOR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Pert I or Part II of item 18) MEDICAL 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year tactory, street, office bldg , etc.) While Hour a.m. et work 21. I certify that (I) (this hospital) attended the deceased from AMA 1.0 M, from the causes and on the date stated above. . 19.6 /., and that death occurred at5. saw, the deceased alive on life. 22a. SIGNATURE SIGNED DIRECTOR 228 ADDRESS 224. PHYSICIAN 23c. NAME OF CEMETERY OR CREMATORY LOCATION BURIAL CREMATION, 236. DATE THEREOF REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATUR VR A15 15M 7-62

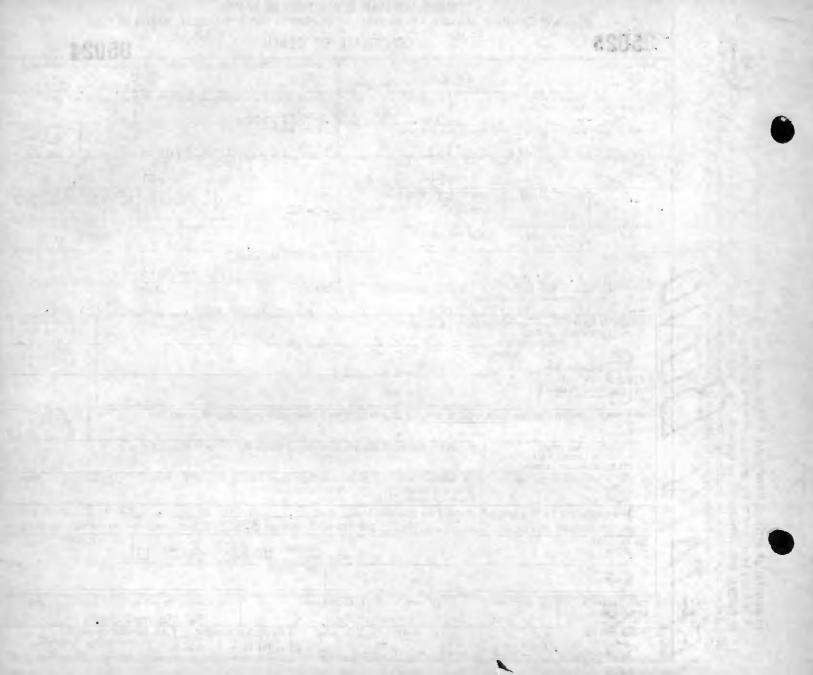
and



MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items 23 05025 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. COUNTY Carroll b. COUNTY Baltimore City MARYLAND ician and campletely filled in by the c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, CLENGTH OF STAY IN 16 requires that the death certificate be executed within 24 hours aft write RURAL and give nearest town) 5yr. 10mo 178. Baltimore Rural -- Sykesville e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS within 72 YES NO K 1802 Woodbourne Avanue Springfield State Hospital 4. DATE Month Doy 3. NAME OF Middle Lost Year DECEASED 1967 Wood April Tessie Mary (Type or print) DEATH IF UNDER 24 HRS. IF UNDER 1 YEAR S. SEX B. DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE 7. MARRIED 北京 NEVER MARRIED last birthdoy) Months Doys Hours 1-3-01 WIDOWED DIVORCED White Female 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT COUNTRY? USA 10o. USUAL OCCUPATION (Give kind of work done the attending physician a nsit permit. Then please remation, ar temoval, and in during most of working life, even if retired) INDUSTRY Baltimore, Maryland Housewife 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Mary Elizabeth Shilgon William H. Clark IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) Springfield Records, Sykesville, Md. none INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: cremat ONSET AND DEATH burial-transit IMMEDIATE CAUSE (o) signand by DUE TO burial, Conditions, if ony, which gove neu mo ruc rise to immediate cause (a), DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate has been use as the last. 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO T fa 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (Stote) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. 20c. TIME OF INJURY Month, Doy, Year Hour a.m. Not While factory, street, office bldg., etc.) of work 4 may be retained by 21. I certify that (# (this haspital) attended the deceased from June 3. 19 61 to April 20 19 67, that (W (we) last Q saw the deceased alive an April 19. 1967, and that death occurred at: 15A.M. fram causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE ATTENDING DIRECTOR PHYS. director, page 3 shauld be filed v M.D. 22d. ADDRESS 22c. PHYSICIAN'S 806125 NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 23b. DATE THEREOF 23o. BURIAL, CREMATION REMOVAL (Specify) Baltimore, Md. Parkwood 250. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 136/ VR A15 (4) 20 M 1/66



301 W. PRESTON STREET, BALTIMORE 1, MARYLAND DIVISION OF STATISTICAL RESEARCH AND RECORDS. CERTIFICATE OF DEATH 1. PLACE OF DESITH 2. USUAL RESIDENCE (Where decased lived, if Institution; Residence before edmission) a. COUNTY b. COUNTY · MARYLAND b. CITY OR TOWN (if outside corporeta limits, E. LENGTH OF STAY IN 16 TOWN (If outside corporata limits, write RURAL and give nearest lown) write RURAL and give nearest town) NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) STREET ADDRESS e. IS RESIDENCE ON A FARM YES NO NAME OF Middla 4. DATE Month ATTRASED 1962 (Type or print) DEATH MMCHMBA and cor carbon nt, within IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH IF UNDER 1 YEAR 9. AGE (In years last birthday) Months Hours event, NDU,10, WIDOWED Z DIVORCED Гепоуе 10s. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY | 11, BIRTHPLACE (County & State, or foreign country) 12, CITIZEN OF WHAT COUNTRY? dong during most of working life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 16. SOCIAL SECURITY NO. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address no, or unkown) | (Ifyesgiva war or datas of service) 1B. CAUSE OF DEATH [Enter only one cause par lists for (a) (b), and (c). INTERVAL BETW ONSET AND DEATH PART I, DEATH WAS CAUSED BY, IMMEDIATE CAUSE (0) DUE TO Conditions, if any, which (b) gave rise to immediate cause **DUE TO** (a), stating the underlying cause last, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) | 19. WAS AUTOPSY CERTIFICATION PERFORMED? 20a, ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of itam 18.] OR CONTRIBUTING TI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY 20d. INJURY OCCURRED 20a, PLACE OF INJURY (Homa, farm, 20f. (City or town) (County) (State) Month, Day, Year factory, streat, office bldg., atc.) While Not While Hour a.m. at work el work 21. I certify that (I) (this hospital) attended the deceased from I in the company of the compan saw the deceased alive on..... 22b. DATE 22a. SIGNATURE ATTENDING: DIRECTOR PHYS. PHYS. -M.D. 22d. ADDRESS 23a BURIAL, CREMATION, | 23b. DATE THEREOF MAME OF CEMETERY OR CREMATORY の意義 24 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 256. VR A15 15M 7-62

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